

# UNIVERSITY OF CAPE TOWN



DEPARTMENT OF SOCIAL DEVELOPMENT

AN ELICITATION STUDY OF THE CONDOM USE BEHAVIOUR AND  
INTENTIONS OF MIGRANTS YOUTH IN SOUTH AFRICA

A dissertation to be submitted in partial fulfillment of the  
requirements for the award of

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MASTERS IN SOCIAL SCIENCE  
(SOCIAL DEVELOPMENT)

By

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Aunt Manyongo Mosima Tantoh

Dissertation to be submitted to Faculty of Humanities of the

University of Cape Town in partial fulfillment of

the requirement for the degree of

Masters in Social Development

2014

Supervisor: Dr. Johannes John-Langba

**COMPULSORY DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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## **ABSTRACT**

Cross border migration is an ordeal that forces migrants in vulnerable situation and compromise their ability to negotiate preventive health care choices. The purpose of this study is to explore the factors that influence behavioural intentions and attitudes of young migrants in Cape Town South Africa towards condom use. The study is a qualitative study that utilized purposive sampling and snow balling as its methodology to investigate and obtained findings to the intentions of migrants' behaviour. It employed in-depth open-ended questions developed for interviews in English. Participants consisted of 20 young migrants in the 18-35year cohort. The 20 respondents are from Cameroon and the Democratic Republic of Congo respectively. The 20 samples consisted of; 13 males and seven females; 10 singles and 10 married; nine single males and one single female; six married females and 4 married males.

The research findings indicated that migrants convened a positive attitude towards condom use. However, the free distribution of condoms may have created a risky sexual behaviour as a consequence to the increased number of girlfriends based on the availability of condoms. Conversely, the researcher found that, those reverent others (parents, siblings, pastors, partners and friends) have the potential of either influencing the behavioural intentions of migrants positively or otherwise, towards testing for HIV and condom use. Evidently, based on further findings health workers may to a certain extend increased migrants susceptibility to health care barriers and challenges. The purposive and snow balling methods employed in this study utilized convenient limited samples of 20 migrants. As a result these findings cannot be generalized to the entire migrants' population. For these reasons, there is a need for further research in a larger scale and also less convenient samples such as migrants in prison.

## **DEDICATION**

This dissertation is dedicated to the Almighty God, who took me out from the mouth of death and gave me a second chance to life. “The grave wrapped its ropes around me; death laid a trap in my path. But in my distress I cried out to the Lord ...He heard me from his sanctuary ... rescued me because he delights in me” (Psalm, 17: 5, 6 &19)

The dissertation is also dedicated to my late parents Mr & Mrs Mosima whose teachings underpinned my notion of life and empowered me to press on despite all odds.

Finally, this study is dedicated to my two glorious sons; Baron and Oscar Tantoh, whose unconditional love towards me enabled me to see beyond the pains and afflictions of the day.

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Firstly, I would like to acknowledge a man who believed in me and guided me holistically towards achieving my vision. He also made available the NFR research grant and the said topic to help inform migrant preventive health policies. This is my supervisor Dr. Johannes John-Langba, thank you Sir.

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## **CHAPTER ONE: INTRODUCTION**

*Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society... This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity*

United Nations(UN, 2003, p. 26).

Inherent in the above quote are the rights ascribed to youths irrespective of resident status. This however, is not the case with migrants' youth as they are susceptible to certain barriers and challenges that influence their ability to wholly participate in safe, respectful, social and sexual behavioural activities. This chapter presents the background to the study and statement of the problem. It further expound on the rationale of the research, explores the research questions, its aims and objectives. Additionally, it illustrates the assumptions and clarifies concepts related to the study.

### **1.1 Background and content**

The present enormous increase in the trend of international migratory flow was termed the “migration era” by Castles and Miller (1993), in an attempt to demonstrate the movement of migrants and its impact worldwide. Though, data are uncertain globally and movements pose a challenge to track, international migration will always be an inevitable tendency. In 2010, international migrants in the world were estimated at 214 million people an increase from 191 million in 2005 United Nations Department of Economic and Social Affairs (UNDESA, 2010),

indicating a slight decrease. In the United States of America, the number of migrants entering the country dropped from 1,130,818 in 2009 to 1,042,625 in 2010; in the United Kingdom, the number dropped from 505,000 in 2008 to 470,000 in 2009; in Spain, it dropped from 692,228 in 2008 to 469,342 in 2009; in Sweden, from 83,763 in 2009 to 79,036 in 2010; and, in New Zealand, from 63,910 in 2008 to 57,618 in 2010 (UNDESA, 2010)

According to the United Nations Development Programme (UNDP, 2009), the estimated number of internal migrants was 740 million, projecting a billion people worldwide. Predictably one in seven of the world's population are migrants (UNDP, 2009). Comparatively, the numbers of people who lived and worked outside their countries of origin globally from 1965 to 1990 were estimated between 75 million and 150 million respectively (UN, 1995) and International Organization for Migration (IOM, 2000). Interestingly, from 2000-10, global migrant stock doubled that of the previous decade. In the 1990s, the global migrant flow grew at an estimated average of about 2million per year. While in the period from 2000-2010, the progression in the migrant stock boosted an estimate of 4.6million migrants annually. Since 2010, the growth in the migrant stock reduced to about 3.6million and stayed constant in the developing countries (UNDESA, 2010). Despite the above explanation, the global number of young migrants reached 34.8million in 2013 (UNDESA, 2013).

Nonetheless, the developing regions projected an increase in the age cohort 20 and under population by 10% compared to 3% in the developed counties. Presently, the developing states host 62% of the global migrant stock under age 20 (UNDESA, 2013) Empirical studies have indicated that the largest generation of adolescents is approaching adulthood in a fast altering world. According to UN (2006), this number is expected to reach 200 million by 2015. It is assumed that their choices may impact on development and social issues sharpening their lives

today as well as the future (Juarez & Martin, 2006). Although half of the world's population is under the age of 25 (UN, 2005), it is imperative to consider issues that frame their rights and wellbeing particularly in the areas of education, work, relationships and health including sexual and reproductive health.

The extent of sexually transmitted infections (STIs), awareness of contraceptives and contraceptive use are essential indicators of sexual health among youth (Dann, 2009). Sexual undertakings among adolescents in developing countries is described as generally high, although there is substantial disparity among countries (Bearinger et al., 2007; Singh et al. 2005), and data validity is often defective (Plummer et al., 2004). South Africa is estimated to have one of the highest epidemics of Human immunodeficiency Virus/ Acquired immunodeficiency Syndrome HIV/AIDS infection, which is one of the deadliest STIs. Recent studies on youth have found that youth aged 15-24 years are increasingly becoming vulnerable to HIV. Though, Shisana et al (2009), projected an estimated 10.9% prevalence rate of HIV/AIDS in 2008, more young women are infected than young men. HIV infected pregnant women aged 15-24 years are estimated at 25.2% Department of Health (DOH, 2005). The 2004 National Youth review stated that 10.2% of youth aged 15-24 were infected with HIV (Pettifor, et al, 2004a). Contrarily, in 2012 those in the 15–24 age cohorts had an overall HIV prevalence of 7.1%, which was lower than 8.7% establish in 2008(HSRC, 2014). Nonetheless, the prevalence of HIV varied by sex, race, gender, locality, and province for this age group (Shisana & Simbayi, 2002; Shisana, Rehle, Simbayi et al. 2005, 2009).

According to the Nelson Mandela/ Human Science Research Council (HSRC)HIV survey (2005) “the largest increase in the national prevalence is found among females aged 15-24 years at 12% in 2002 and 16.9% in 2005” (p. 45). Provincially, NwaZulu Natal is swiftly becoming one

of the provinces with the maximum intensities of HIV/AIDS among youth, rated at 12.0%, in 2012, a decrease from 16.1% in 2005 (HSRC, 2014). Presently the Limpopo province has the lowest HIV prevalence rate among young people at 3.1% and provincially at 1.6%. The Western Cape progressed from the lowest prevalence rate of 2.3 in 2005 to 4.4% in 2012 and registered as the only province which experienced an increase. As stated, on the National Youth Survey, 15.5% of young women were HIV infected contrary to 4.8% of men (Pettifor, et al, 2004a). A related HIV prevalence found in the HSRC study specified that, HIV occurrence in the 15–49 year group is 18.8%. Females continue at higher risk of HIV and are 1.6 times more likely than males to be HIV positive (HSRC, 2014). The HIV survey (2005) also specified that “the female to male ratio for HIV infection in 2005 was also highest among youth aged 15-24 years”(p.45), as the incidence in females at 16.9% was almost four times that of males at 4.4%. According to DOH (2005), the age group disparities were evident in the antenatal survey as the HIV prevalence was estimated at 16.2% for 15-19 year-olds and 30.8% for 20-24 year-olds. Pettifor. et.al’s study found similar age and gender patterns (Pettifor et al, 2004a) as the above.

However, the use of condom is promoted as one of the key HIV prevention methods in South Africa. According to Pettifor et al, 2004a & Shisana et al (2005), two-thirds of youth have never used a condom; half had used condoms at most recent intercourse. 33-42% used condoms regularly (James et al, 2004; Pettifor et al, 2004). Furthermore, men were more likely to use condoms at last sex and to use them regularly (Pettifor et al, 2004a; Shisana et al, 2005).

## **1.2. Statement of the research problem**

The South African economy is one of the biggest in Africa and has the tendency of attracting migrants from other African countries. The total number of young migrants stood at 34.8million in 2013, with a 10% increase in the developing countries (UNDESA, 2014).

However, the down side of this has rendered the country vulnerable to proliferation of various diseases one of which is HIV. The process of migration in most cases is an ordeal in the sense that most migrants are running away from diverse ills plaguing their environment such as: the attacks on Christians in Nigeria the by extremist group Boko Haram accused for the recent killings of more than 75 people in the capital city Abuja and abduction over 230 school girls in the month of April (Olusengun, 2014).

Taking into account the above examples and the lack of practicality of the South African Refugee Act (Act No. 130 of 1998)), in which migrants are entitled to the same basic health services and basic primary education which the inhabitants of the republic receive from time to time. It is important however not to assume the applicability of the above act in all cases as affirmed by (Landau & Wa Kabwe-Segatti, 2009) “One must also recognise the limited influence of public policy on practice. With poor implementation capacity and endemic corruption within the police and border officials, state policy of any kind is unlikely to achieve its desired effects, whatever those may be” (p. 2). The porous nature of the policy implementation have made migrants exceptionally vulnerable in the receiving countries and are left with little or no option but to oblige to any available surviving mechanisms. Some become; gay sex workers, prostitutes, child wife and older women who take advantage of migrants boys as sex apparatus. Under these challenging conditions, they command very little power to negotiate the use of condom and the clinics where support could be obtained are sometimes biased towards migrants. This point is also sustained by the studies conducted by (Amon & Todrys, 2009; CoRMSA, 2009; Human Rights Watch, 2009a, 2009b; Landau, 2006b; Pursell, 2004; Vearey, 2008a) in which they established that one of the greatest challenges faced by international migrants is the problem of access to public-health services in South Africa. This however, could be attributed to the assumption that protective policy has not been successfully converted into protective practices.

### **1.3. Aims and objectives of the study**

The aim of this study is to explore the factors that influence behavioural intentions and attitudes of young migrants towards condom use. The specific objectives of the study include to:

1. Examine attitudes towards condom use by migrant youth in South Africa.
2. Identify subjective norms that influence condom use behaviour and intentions of migrant youth in South Africa.
3. Determine how the Perceived Behavioural Control influence condoms use behaviour.
4. Understand the influences of acculturation on condom use behaviour and intentions of migrant youth in South Africa.
5. Identify the challenges and barriers facing young migrants in shaping their attitude, beliefs and subjective norms in relation to their behaviour and intentions towards condom use.

### **1.4. Research questions.**

The purpose of this study is to explore the factors that influence the use of condom as prevention behaviour among migrants' youth in Cape Town, South Africa. The researcher intends to further study attitudes, subjective norms and behavioural intentions of these youth as migrants. The Theory of Acculturation and Planned Behaviour will be used to design my study and data collection instruments. The research questions this study addressed included:

1. How do the attitudes of migrant youth in Cape Town, South Africa influence their intentions towards condom use?
2. What are the subjective norms that impact on condom use behaviour and intentions of migrant youth in South Africa?

3. To what extent does the Perceived Behavioural Control influence condoms use behaviour among migrant youth in South Africa.?
4. How influential is acculturation on condom use behaviour and intentions of migrant youth in South Africa?
5. What are the challenges and barriers facing young migrants towards accessing preventive health care services?

### **1.5. Rationale and significance of the study.**

As enshrined in section 27 of The Constitution of the Republic of South Africa (1996) everyone has the right to access health care services, including sexual and reproductive health care. It further affirms the responsibility of the state to take realistic legislative and other measures towards achieving a progressive realization of the above right. The National Youth Policy (NYP, 2009-2014) recognises teenage pregnancy, maternal mortality, reproductive and sexual health, HIV and AIDS as specific health challenges that youth in South Africa encounter. It recommends the improvement of access to youth-friendly health related programmes and services. It is however, important to note that most migrants find themselves in vulnerable circumstances in the receiving counties. An example will be that of a male migrant spouse who leaves home daily and works as sex worker, without the knowledge of his wife (personal communications, 2011). Notwithstanding these limitations, the quest of migrants to survive is subject to their ability to or not to adhere to adverse social conditions and the availability and accessibility to health care facilities.

The South African National Strategic Plan on HIV, STIs and TB (NSP) 2012 – 2016 South African National AIDs Council, (SANAC, 2011), categorised young people as a high-risk group and aims to decrease the occurrence of new HIV infections by 50% and reduce the impact



of HIV and AIDS & TB on individuals, families, communities and society by improving access to suitable treatment, care and support. It is against this background that this study seeks to ascertain the macro and micro policy mechanisms put in place to curb the challenges and barriers to condom use by young migrants of both genders in Cape Town. Understanding these challenges may inform and allow government improvement of the wellbeing of young people through the prevention of illness, the promotion of healthy lifestyles, and the enhancement of health care dissemination structure by concentrating on the accessibility, competence, excellence, and sustainable youth and adolescent hospitable health services(DOH, 2012).

This study is expected to inform the larger study and influence on-going efforts to effectively target and support young migrants by clearly identifying the key Challenges and barriers affecting their ability to negotiate the use of condom. Hence, the researcher hopes that this study will contribute to the formation of attitudes, subjective norms and behavioural intentions towards condom use specific to migrant youth in South Africa.

It could also be said that, the study has the potential in influencing or contributing to the NSP which practice the four following objectives namely; Focus on social and structural approaches to HIV and TB prevention, care and impact; Prevention of HIV and TB infections; Sustain Health and Wellness; and Protection of Human Rights and Promotion of Access to Justice. Evidently, there exist a gap in the provision of and access to health care services to migrant.

## **1.6. Assumptions**

In South Africa, the HIV epidemic is presently experiencing new infections amongst youngsters aged 15 to 24 years. Studies indicated that more than half of STI's amongst youths were recorded, and some were left untreated. It further specified that about half of patients who were managed for symptomatic STIs may be co-infected with HIV, and reported HIV co-infection of about 80% in some communities (SANAC, 2011).

Notwithstanding, the continuous occurrences of conflict, war, economic instability and natural disasters, have influenced the influx of other African nationals into South Africa. According to International Organization for Migration (2000), the impositions of stringent migration policies by developed countries have resulted in an increasing number of sub-Saharan migrants within the continent. Studies piloted by the Southern African Migration Project (SAMP) have revealed that cross-border migration into South Africa is on the rise since the 1990s (Mattes & Crush & Wayne, 2000). Parents have migrated and the children who stayed behind have eventually joined their parents. Although they travelled at different stages in life, some as children and others as youths, the assumption is that these youngsters have developed certain attitudes, beliefs and behavioural pattern in their home countries that will experience a shift in their receiving country South Africa because they are physiologically vulnerable, susceptible to peer pressure and have a predisposition to engage in risk-taking behaviour.

According to young female pregnant migrants most female youths who migrate into South Africa, come in as a spouse to older migrants who in most cases are aware of their HIV positive status but refuse to disclose. As a counsellor, in most of my sessions, these young migrants test positive with very high CD4 count of above 1000, which is medically explained as recent infection. However, because they rely exclusively on their male partners it becomes very difficult

for them to negotiate safer sex and administer treatment (Personal Communication, 2010). As a consequence, irregular migrant, specifically women, may find themselves in exceptionally vulnerable situations, when discriminated against on numerous grounds. Underneath these multiple layers of discrimination lie the complex and unequal treatment that migrants receive when accessing health services (IOM, 2013). This study is based on the following assumptions;

1. The attitudes of young migrants are susceptible to peer- pressure and have a predisposition to engage in risk-taking sexual behaviour.
2. The attitudes and behavioural intentions of most migrants towards condom use may experience a shift in their receiving countries due to the influence of acculturation.
3. The vulnerability of most migrants have compromise their ability to negotiate for preventive sexual choices.
4. Lack of proper documentation is an ordeal that has incapacitated migrants' ability to access preventive health services.

### **1.7. Clarification of concepts**

*Youth..* The South African definition for a youth is any individual between the ages of 14 - 35 (Republic of South Africa, 2000). The DOH definition of 'youth' which is aligned with that of the World Health Organization (WHO), defines a youth as an individual aged 10 to 24. According to Statistics South Africa (STSA, 2012), young people in the 10 to 24 years cohort amount to about 30% of the total population of South Africa and out of a the total population of 51 770 560, 4 594 886 (8.9%) were aged between 10 and 14 years; 5 003 477 (9.76%) between 14 and 19 years and 5 374 542 (10.4%) between 20 and 24 years.

Of interest to this study are the youth in the age groups of 18 - 35, hence the word youth in this study will refer to persons within the ages of 18-35 years old. Ascribed to this, is the

reason that young people between the ages of 18 - 35 have higher levels of maturity than those in the younger age groups. Furthermore they have acquired and accumulated experiences that will influence their attitudes, subjective norms and perceived behaviour towards the use of condoms. According to Lewis et al (2009), college students do not practice safe sex and have the tendency of accommodating multiple partners. Additionally, college students involve in behaviours, such as binge drinking that place them at even greater risk of having unprotected sex (Fisher, 1990).

Noting the compelling nature of this evidence, the Convention on the Rights of the Child (CRC) 10 recommends that related countries “develop and implement, in a manner consistent with adolescents’ evolving capacities, legislation, policies and programmes to promote the health and development of adolescents”... it undoubtedly provide for “adequate information and parental support to facilitate the development of a relationship of trust and confidence in which issues regarding, for example, sexuality and sexual behaviour and risky lifestyles can be openly discussed and acceptable solutions found that respect the adolescent’s rights (art. 27 (3);” (CRC/GC/2003/4, paragraph 16).

*Human Immunodeficiency Virus (HIV).* HIV is a virus present in infected human body fluids. It attacks the human cell (white blood cell) and replicates itself. Its origin is still a debatable topic that will not be further discussed in this study. Diagnoses of the were first made in early 1980s among gay white men in America known then as slim disease. There was a shift in the disease as heterosexuals black are now amongst the highest rate of infected cases worldwide. Internationally, HIV is transmitted predominantly through infected drug needles. Contrary to the West, HIV is mainly transmitted In Africa through unprotected sex. Taking into consideration, the above, condom use behaviour is paramount in Africa to curb its growing rate of infected cases.

*Acquired Immunodeficiency Syndrome (AIDS).* AIDS is the progression of HIV, taking into account the; CD4 count cells, lifestyle, poverty, social and psychological state of an HIV positive individual. Presently, South Africa has progressed in the distribution of AIDS treatment. Presently, the government is giving free treatment (antiretroviral) to all infected individual with a CD4 count of 350 and below. This is a positive move from former president Thabo Mbeki's denials policy that left many dead.

*Migrant.* The concept migrant is highly contested at the international level and holds no collectively acknowledged definition. In this context, the decision to migrate is initiated freely by an individual for reasons "out of personal convenience" short of interference of an outside compelling factor in an attempt to develop his/her material or social circumstances to enhance either themselves or their family (IOM, 2004).

Migration can be defined as the movement of an individual or individuals in their state of residence or across international boarder for political, economic or social reasons (IOM, 2004). According to The United Nations, a migrant is an individual who has resided in a foreign country above a year regardless of the motives, voluntary or involuntary, and regardless of the regular or irregular nature of the means used to migrate. Concurrent with the above definition, is the idea that shorter period's travellers or tourists and businesspersons will not be recognized as migrants. There are different kinds of migrant, it includes; economic migrant, irregular migrant and skilled migrant amongst others. The study focus is on young people who were born in their home countries and moved in to South Africa to either join the family or to pursue their own development.

*Migrant youth..* For the purposes of this study, a migrant youth is defined as a person aged 18-35 years who was born overseas (home country) and is currently residing in the receiving

country in this case South Africa. The term 'migrant youth' also includes young people who came to South Africa as refugees

*Cross-border migrants.* It is appropriate to consider cross-border migration in terms of the movement of labour from the South to the North. Cross-border movement of goods, services and capital has developed in volume and is less restricted. Migrating to work is a significant trend especially in developing countries of Africa, Asia, Ocean and Latin America. According to the IOM (2000) labour migration is generally defined as a cross-border movement for purposes of occupation overseas. Kok et al (2003) argued that migration should preferably be defined as crossing the borderline of a predefined spatial entity by individuals engaged in a change of residence. The above statement is not completely true, as time and space are important factors in cross-border migration. According to the South African, census-based migration data over different periods, it illustrated that the 1980 and 1996 migration data were limited to movement between different places of 'usual residence'. However, in Census 2001, Statistics South Africa ditched the restriction and migration-origin data was conveyed without allegiance to 'usual residence' in reverence to the place of prior residence (STATSA, 2002).

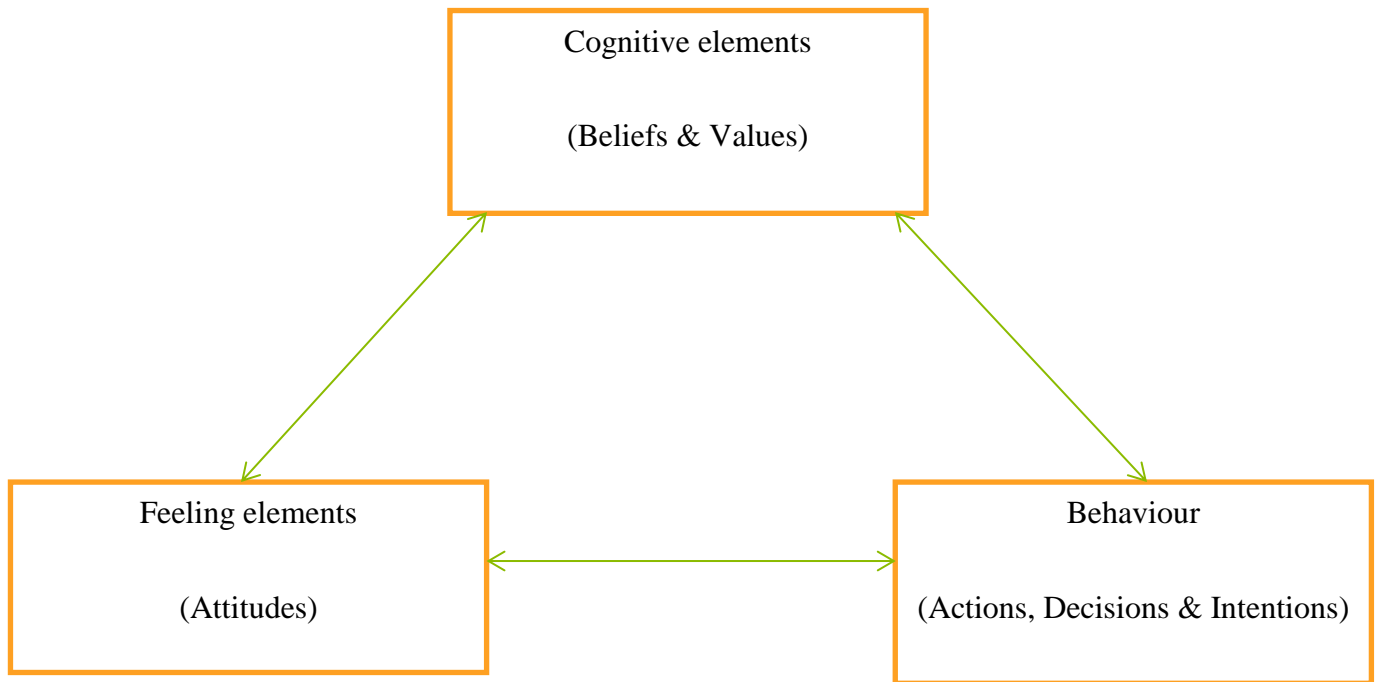
The principal challenge faced by cross-border migrants in South Africa is accessing public health services. While the South African Constitution allows health care service for all, there is a dominant discourse particularly within the healthcare system which adversely allies migration with healthcare seeking. Healthcare providers have indulged in restricting and denying cross-border migrants access to health services while blaming them for the present extra problem to a public healthcare system that is already over-stretched (Moyo, 2010).

*Attitudes.* The definition of the concept attitudes vary as psychologists have propagated different definitions. In the early 1930s, attitude was defined as a mental or neutral state of readiness, organized through experience, applying an ordinance or active influence on the

individual's response to all objects and circumstances to which it is associated (Allport, 1935). Similarly, Baron and Byrne (1987) describe attitudes as a long-term, overall assessment of individuals, objects, or issues. He further affirmed that attitude is lasting, and prevails through time, whereas temporal feeling cannot be regarded as an attitude. It is of importance to acknowledge that in the above definition, Baron and Byrne talked of time and space as essential ingredients of attitudes and as illustrated by (Vaughan & Hogg, 1995). They attested to the comparatively permanent-persist nature of attitude through times and situations, where a brief feeling is not an attitude. This is based on the notion that emotional response is regarded as just a feeling.

For the purpose of this study, attitude will be perceived as a complex mixture of things we have a tendency of calling personality, beliefs, values, behaviours, and motivations. Here an individual's attitude is referred to their emotions and behaviour. An individual's attitude in respect to preventive medicine incorporates his or her opinion of the concept, known as thought. The manner in which they relate to this topic is perceived emotion. Their actions in behavioural engagement will be as a result of attitude developed to prevent health problems. The above embodies the tri-component model of attitudes (see Figure 1). An attitude comprises of three components: an affect (a feeling), cognition (a thought or belief), and behaviour (an action).

**Figure 1: A tri-component model of attitude: Adapted from (Oskamp, 1991, p.8)**



*Subjective norms.* Is defined as an individual's perception of how the people important to them view and influence their performed behaviour. Subjective norm is assumed to comprise of a more traditionally measured injunctive component in an instance when an individual believes his/her social network wants them to perform a particular behaviour and a descriptive component in a case where one's social network executes a behaviour;( Ajzen, 2000). Recent empirical studies on descriptive norm reflect on the growing patronage for its predictive authenticity upon behavioural intention (Conner & Sparks, 1996, 1999; White, Terry, & Hogg, 1994). Furthermore the theoretical support in the extension of normative pressure includes social pressure of fitting into a group who possibly will or will not perform the behaviour (Whiteetal, 1994). Nevertheless, according to Ajzen (2000), the inclusion of descriptive norms is primarily for more variability in



the subjective norm measure. This also reflects on the injunctive norms with a restricted range due to high social interest.

*Perceived behavioural control.* This refers to the extent, to which an individual feels able to enact his /her behaviour, is termed perceived behavioural control. It consists of two facets: firstly. It depends considerably on an individual's control over the behaviour and the level of confidence an individual has towards his/her ability to perform or not perform the behaviour. This is defined by control beliefs around the mutual power of the situational and internal aspects to impede or facilitate the enactment of the behaviour (Ajzen, 1991).

In like manner, Terry and O'Leary (1995) insists that, perceived behavioural control predicts behaviour not intention as in the case of self-efficacy. Self-efficacy as argued by researchers, predicted exercise intention, not behaviour (Terry & O'Leary, 1995; White, Terry, & Hogg, 1994). Contrarily, Sparks, Guthrie, and Shepherd (1997) differentiated between perceived difficulty and perceived control. They maintained that difficulty measures may be more meaningful to those participating in a study and perceived difficulty is more related to perceived behavioural control as demonstrated by Ajzen in 1991.

*Acculturation.* The concept of acculturation has conflicting interpretations. However for the purpose of this study, two definitions will be employed. Acculturation comprehends those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups (Berry, 2003).

Inherent in this definition, is a need to distinguish acculturation from culture change which is an aspect and assimilation in the occasional phase of acculturation (Redfield, Linton, & Herskovits, 1936).

In the second definition, acculturation is perceived by the Social Science Research Council (SSRC, 1954), as “...culture change that is initiated by the conjunction of two or more autonomous cultural systems. Its dynamics can be seen as the selective adaptation of value systems, the processes of integration and differentiation, the generation of developmental sequences, and the operation of role determinants and personality factors”(p.974). The prominence of these definitions is upon the collective viewpoint of the acculturation process which comprehends change to occur in both migrants and members of the host community.

*Condom.* A condom is a low-cost but simple device that is expected to attain the demanding routine requirements. Though the product quality has improved over time through improved process control and strict production standards, there has been little recorded change in its technology in the last 10 years (UNFPA, 2003). There are two types of condoms namely; the female and the male condoms.

UNFPA, (2003), describes the female condom as a loose-fitting 17 centimetres long polyurethane sheath with a flexible ring at each end. Presently, it is the first existing technique available to women and girls for the dual performance and control of unwanted pregnancy and sexually transmitted infections. The female condom is inserted several minutes into the vaginal before sexual intercourse. The inner ring of the loose-fitting polyurethane sheath sits inside the vaginal track while the outer ring lies on the mouth of the vaginal. The condom adapts to the female internal temperature and settles in nicely. Failure to insert the condom several minutes before intercourse, the sheath will produce a noisy sound that will impede the process.

The female condoms was introduced to supplement the male and help curb the challenges of inequalities faced by women which usually acts as barriers for negotiating the use of male condoms. In 2008, the total dispersal of the female condoms increased to above 33 million indicating a steady increase in three subsequent years (NNFPA, 2003).

According to WHO, UNFPA and UNAIDS, (2004), “The male latex condom is the single most efficient, available technology to reduce the sexual transmission of HIV and other sexually transmitted infections and offer dual protection for the prevention of unintended pregnancy” (p.1). It is placed on an erected penis before sexual intercourse. Both condoms are removed after ejaculation and discarded in a safe manner. The promotion of condom use is a critical constituent of any HIV/STI prevention and care model. According to the UNAIDS (2004), the effective advancement of condom use as part of an inclusive HIV prevention model devoted on behaviour change is certain to decrease HIV.

*Condom Use Behaviour.* Contraception use is a multifaceted aspect in decision making and is subjected to an individual’s beliefs around the effectiveness of contraception and its side effects (Gilliam, Warden, Goldstein, & Tapia, 2004), beliefs about ethics and social acceptance (Leonard, Chavira, Coonrod, Hart, & Bay, 2006), awareness about procedures (Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006), and the duration of the said relationship (Harvey, Henderson, & Casillas, 2006). The above obstacles are evident in the youth, who despite their ability to conceal the use of preventive methods, lack proper information and access to contraception and care.

Although, condom use is the most utilized contraceptive method amongst Latino youth, men are responsible for initiating its use. Studies have indicated strong predictors of condom use in men’s attitudes regarding their responsibility and perception in relation to contraception use, its effectiveness, and their ability to communicate with their partners (Murphy & Boggess, 1998; Sheeran & Taylor, 1999; Soler et al., 2000).

*Condom use Intention.* The concept intention is highly contested in definition (Warshaw & Davis, 1985). According to Fishbein and Ajzen (1975) the term intention represents an individual’s personal prospect in his or her willingness to perform behaviour. However, in Ajzen,

(1991), revamped version, intentions are expected to capture the motivational factors that impact on behaviour; they are pointers of the length through which an individual is willing to try, the extensive effort he/she is prepared to exert and perform the behaviour.

For the purpose of enhancing this study, it was important to evaluate if an individual's intention to use a condom is the most immediate, and important, predictor of his/her behaviour, taking in to consideration, the complexity of sexual behaviour, it remains debatable whether intentions do indeed predict future condom use. The findings of this study indicated that migrants had a positive control over their intention to use condom.

In an attempt to narrow this debate, we will look at two theories that have impacted on the concept of condom use intention. The theory of reasoned action (Ajzen & Fishbein, 1980) and the theory of planned behaviour (Ajzen, 1985, 1991) are the psychological models of behaviour that have been functional to condom use. According to Ajzen and Fishbein (1975; 1980) the theory of reasoned action, affirms that the intention to perform behaviour is a key predictor to determine the occurrence of that behaviour. Whereas the theory of planned behaviour (Ajzen, 1991) expands on the theory of reasoned action and advocates that the performance of behaviour is subjective to the degree of personal control an individual has over the behaviour. Control in this sense is the incorporation of internal and external facets such as, skills, knowledge, willpower, resources, opportunity and having a plan. In essence, when an individual perceives little control over the behaviour due to the lack of one of the above listed factors, then their intentions to perform become low, though they possess favourable attitudes and subjective norms toward it (Ajzen & Madden, 1986). Despite their diverse views, both theories agreed that Intention predicts actual behaviour.

Notwithstanding, Kashima, Gallois and McCamish (1993) suggests that since condom use is less an individual than a joint behaviour it entails the collaboration of a sexual partner. Bearing

in mind that individuals are uniquely different, it will also reflect on their intentions concerning condom use. Hence, the fact that intentions attained from one partner may not project their joint behaviour. Furthermore, condom use involves, been able to access and own the resources (e.g. condom) and the opportunity of having a potential sexual partner. These elements are assumed to impact on the connection between intentions and behaviour (Liska, 1984).

## **Conclusion.**

Although there is awareness in most communities regarding HIV/AIDS issues due the evidence in infected cases and increasing number of NGO /CBO rendering support to the people. More effort is need in the field of HIV/AIDS research, especially regarding young migrants in South Africa. It is important to note however, the discipline of psychology has the advantage of understanding human behaviour. In contrast, current studies indicated that little has been has done to build the knowledge capacity around behaviour change in South Africa.

## **CHAPTER TWO: LITERATURE REVIEW**

This chapter reviews existing scholarly materials on migration, health, youth's attitudes and behavioural intentions towards condom use. Policy and legislative frame work on migration and HIV/AIDS will be examined. The chapter will further analyse theoretical paradigms of the theory of Planned Behaviour (TPB), the theory of Reasoned Action and the theory of Acculturation as conceptual frameworks that underpins the study.

### **2.1. History of migration in South Africa**

Historically, migration in Africa was categorized by the circulatory labour migration of males (Timaues & Graham, 1989). The history of migration and its movement into South Africa could be traced before the coming of the first white migrants under the leadership of Jan van Riebeck in 1642. The recorded movement of black Africans in the region took place before and after the arrival of white settlers (Timaues & Graham, 1989). The labour migration pattern initiated in 19th century in South Africa used hiring agency to hire workers from Mozambique, Namibia, Lesotho, Malawi, Swaziland and Botswana for the diamond and gold mines (Wilson, 1976). Internally, due to the impact of the Zulu war and the imposition of colonial national borders most families were separated as some were pushed northward. These push and pull factors influenced migration on the basis of maintaining family ties and seeking greener pastures (Mattes & Richmond 2000; Stern & Szalontai, 2006). The 1880s and early 1890s witnessed a boom in the mining industry and attracted migrants. This was in relation to its favourable wages which boasted twice as compared to Irish workers (Harries, 1982:143). As the mining industries grew there was a need to build large corporations capable of the financial burden and cost of the

growing firm. Cheaper labour was needed, in response to this, 64.000 Chinese labourers were imported between 1904 and 1907. In 1973 and 1970, 297.000 nationals from Malawi, Mozambique and Angola were reported and in 1980 there was an increase of Bantustans (Transkeian migrants) working from 33.000 to 245.000 (Graaff, 1986).

The period of 1920s to mid-1960s accounted for undocumented migration (or clandestine) this was accommodated within certain conditions. Although approved consent were granted to few irregular migrants until 1928 from the region, undocumented migrants in the urban areas or at the border from the 1920s to the mid-1960s had to choose between accepting permits to work on white owned farms or repatriation.

Empirical studies indicated a decline in foreign nationals based on; the withdrawal of Malawians mine workers by their president the independence gained by Mozambique and Angola in 1970, witnessed a tremendous decrease of the above nationals amongst others from the mines, from 297.000 in 1973 to 182.000 in 1980 (Graaff, 1986). The influx of asylum seekers and refugees from the rest of the continent as well as from the West is one of the most substantial changes in the patterns of migration realized since 1994. An estimated 150,000 claims/applications for asylum were acknowledged by the Department of Home Affairs between 1994 and 2004, of which 26,900 asylum seekers were approved refugee status. 53,363 asylum claims were projected in 2006 (the highest recorded number). At the end of 2007, legally recognized refugees was projected at 36 800, asylum seekers, total currently open asylum applications amounted to 89,000 and new asylum applications were estimated at 45,673 (of which only 5,879 were decided, adding to the backlog). Economic migrants issued with individual work permits (not including corporate permits) was at 19 601 in 2006/7 (Department of Home Affairs, 2008). From the 2006 claims, 78% (41,437) were from men; while women comprised of 20% (10,769) and 2% (1,155) were children. Approximately 5,342 early decisions

were reached regarding the 2006 claims for asylum. Angola, Burundi, Zaire (DRC) and Somalia were the predominant claimant-generating nations between 1994 and 2001. Other countries such as; Cameroon, Nigeria, Senegal, India and Pakistan, have also conveyed a noteworthy increase in claimant. Rejection rates are therefore high to claimants from countries in this latter category indicating previous attempt of economic migrants to use the refugee system and settle in South Africa.

The 2006 data which analysed asylum from the period 1994-2001 illustrated variations in the countries of origin of applicants, with Zimbabwe identified as the most distinguished largest source of asylum claims in 2006 comprising over a third of all claims (18,973). Malawi, a new and significant source of asylum claims was estimated at 6,377 claims (12%). Ethiopia, Bangladesh, Somalia and the DRC were indicated as the other important source (IOM, 2010).

## **2.2. International migration policies and legislation**

*The international community has failed to... meet the challenges associated with international migration and that states and other stakeholders must pursue more realistic and flexible approaches to international migration. (Global Commission on International Migration, 2005 p. 2 & p.79)*

Migration policies and framework are put in place to regulate the flows, circumstances, significances and magnitude of international migration. Generally, international immigration policies for the destination countries are geared towards enforcing the needs of the labour market and demographic objectives. Immigration policies are implemented through Governments laws, regulations and programme measures fashioned to manage the volume, origin, direction and



composition of migration flows objectively (UNO, 2013). Nonetheless, these should be accompanied by human rights issues, which call for a rethinking of global migration policies.

International policies have failed in relation to migrants as most developed countries and regions have initiated migration legislations characterized by regularization of flows and measures to improve the integration of migrants in the receiving countries. In this regard, the 2007, European Union legislation impacted on the 28 European Union countries' migration policies and that of the neighbouring countries in the European Union accession process, known as the "Blue Card." The "Blue Card" is an EU-wide work permit initiated to create an enhanced systematic and appealing atmosphere for talented foreign nationals. This move was implemented by a majority of European Union countries, in an attempt to establish conditions of entry and residence for third-country nationals towards acquiring highly qualified employment (European Union, 2009).

Notwithstanding, according to Parkes and Angenendt, (2010), the art put in place measure for member states to afford substantial decision to reduce the consequent range of Blue-Card holders to work throughout the Union (Arts. 18 & 19 as well as 8(2), 9 & 13). The member states reserve the right to choose on the volumes of migrants allowed to enter their labour markets on admission rules (Art.6). They are also permitted leeway to maintain their own higher local provisions (Art. 4). Inherent In the above policy is the acquisitions of talent from the developing countries also known as brain drain. However, little is said about training of these nationals towards enhancing their capacity, taking into account the differences in technology and resources available to these migrants in their home countries and the standard of international competition. Critiques have argued that firstly, this move did not take into consideration the present quality of migrant labour and also that it is used as an attempt to curb migrants flow in European countries.

Nonetheless, in terms of health which is the focus of this study, this policy makes no provision for migrant's access to health services.

Recently, countries such as; Bulgaria, Chile, the Czech Republic, Finland, Ireland, Lithuania, Mexico, Poland and Slovakia approved and integrated migration policies as part of their national strategies and development plans (OECD, 2011; 2012; 2013). Poland adopted its first migration strategy in 2012 that stressed the need for Poland to be liberal to immigrants with required skills and to enable their integration (OECD, 2013). Though skilled workers circulate effortlessly, those who are not in the elite class have fewer prospects in accessing migration opportunities within a legal framework.

According to the Universal Declaration of Human Rights (Article 13-2), "Everyone has the right to leave any country, including his own, and to return to his country." Nonetheless, if the right to emigrate is recognized, then the compatible right to immigrate which is of relevance in this study should be of particular importance because contemporary migration policies are progressively categorized by restrictive mechanisms that make international mobility challenging. Although, governments of receiving countries are increasingly incorporating Human rights approaches in their migration policies, (Article 23) the human right to free choice of employment and (Article 25) the right to an adequate standard of living are hard to achieve when migration opportunities are scarce.

In 2011, Mexico in its attempt to safeguard and protect the human rights of all migrants redefined its migration policy by endorsing the human rights approach. The Mexican government gave prominence to family reunification issues, and migrants' access to health care and education, particularly to children United Nations News Centre (UNNC, 2013).

In most European countries, hosting about one third of the global migrants stock, migrant status determines the accessibility to basic social protection and health care. However, migration and border control have been increasingly integrated into security frameworks that emphasize policing, defence and criminality that could undermine the human rights-based approach (UNNC, 2013). Current migration and border policies could eventually exhibit susceptibility, not only for migrants, but also for the human rights and democratic values that rest at the nucleus of Western states. “The morality of frontiers, where human rights are at their lowest, is threatening the interiors of the countries” (Hayter 2000, p. 150). Harsh border control methods might not be in line with the harmonious functioning of democratic states. “Building walls is a peculiarly lonely job and an admission of the inadequacy of the system” (Nett 1971, p. 224), therefore there is a dire need for “smart borders” that, functions as filters rather than acting as obstacles, though it might raise concerns over human rights and privacy (Andreas, 2003). Schoenholtz (2003) affirms that through the sharing of intelligence and co-operation towards the control of migrant flows beyond national borders, states may moderate security risks while permitting fluid border crossing.

Although, the rights of international migrants are protected under the 1990 United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (United Nations, General Assembly, 1990). Notwithstanding, on the condition that migrants are refused entry in to a desired country of purpose within their reach, due to preventive policies and or border implementation, they will rely on the third parties’ promises. “The more effective migration controls become, the more lucrative smuggling becomes and the higher the fees that are payable by those who are smuggled” (Doomernik 2004, p.43). However, the October, 2013 universally approved Declaration of the General Assembly’s second High-level

Dialogue on International Migration and Development called upon the affirmation of its Member States to their commitment towards human rights of all migrants (UNNC, 2013)

According to the WHO policy on migrants' right to health (WHO, 2010) , though a number of human rights treaties make reference to the right to health, Article 12 of the ICESCR is the most articulate by recognizing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The main features of the right to health are that it comprises of both ‘freedoms’ and ‘entitlements’ (IOM, 2013, P. 17)

Conferring to IOM (2013), freedom denotes the right to be free from non-consensual and uninformed medical treatment, medical experimentation or forced HIV testing. Freedom from torture and other forms of cruel, inhumane and degrading treatment is another important component of the realization and protection of the right to health. Consequently, migrants may be denied access to the diagnosis of and treatment for TB and other health related illness as a result of their legal status. Hence, they may not access health facilities for fear of repatriation. Subsequently, this action will delay their ability to seek treatment due to lack of knowledge and information on the availability of resources. Moreover, those migrants who had commenced treatment are unable to continue care as deportees. Medically, any discontinuation of treatment on TB /HIV will enhance the development of a stronger germ or virus.

Another significant feature is entitlements. This is the obligation of the state to make provisions for satisfactory health services essential for the apprehension of the utmost achievable standard of health. Conversely, entitlements comprise the right to a system of protection, which provides prevention, treatment and control of diseases on an equal basis for all. It further entails access to information and education about health, particularly for matters surrounding unhealthy or risky behaviour, required medicines and sexual and reproductive health-care services. It is

important to note, however, that “discrimination may be especially acute in relation to pregnancy. Female migrant workers may face mandatory pregnancy tests followed by deportation if the test is positive; coercive abortion or lack of access to safe reproductive health and abortion services, when the health of the mother is at risk, or even following sexual assault; absence of, or inadequate, maternity leave and benefits and absence of affordable obstetric care, resulting in serious health risks. Women migrant workers may also face dismissal from employment upon detection of pregnancy, sometimes resulting in irregular immigration status and deportation” (IOM 2013, p. 31).

Despite the above Gender-specific health vulnerabilities of migrants, the Israeli High Court of Justice in April 2011 obliterated a ruling authorizing the deportation of pregnant migrant workers and affirmed its unconstitutional nature. In an attempt to comply with the above-mentioned entitlements and freedoms, states should according to the interpretation of the CESCR General Comment No. 14, right to health take into considerations the following. Endeavour that health facilities, goods and services are available, accessible, acceptable, of proper value and appropriate to all segments of the population, including migrants (IOM, 2013).

### **2.3. South African legislative and policy framework on migration**

The migration policy of South Africa bears the mark of its history. President De Klerk’s administration inherited a migration policy in 1989 which was characterised by the classical colonial settlement policy, discriminatory in nature and very incremental. Legislation was steadily associated based on the principle of distinct economic growth that served the aims of the two-gate policy from 1937 to 1986. These period experienced a broadening gap between the intentions of legislative stabilization and an in-depth political alteration.

In the early 1990s, laws modifying immigration basically ersatz the principles of the 1937 Aliens Control Act. Section 4(3) (b) of the act indicated that “likely to become readily assimilated” with the European occupants of the Union and that they should not characterize a threat to “European culture.” From 1991, the Aliens Control Act was declared illegitimate and in dire need of constitutional review by 2002; to improve the immigration law.

The inconsiderate lack of appeal procedures offered in the 1991 Act (Section 55),, was replaced in the 1995 text and the protection of certain fundamental constitutional rights introduced (section 54(6) on dignity, freedom, the security of persons, and the right to private property). However, the treatments of migrants by the natives have little bearing of the section 54(6). According to a study conducted on xenophobia in 2002, respondents were allegedly brutalized and manhandled by both police officers and locals (Harris, 2002). In 1999, after a Rwandan refugee suffered an attack from the hands of locals, (beating and stabbed) by local tugs, this is how dignified and secured he felt. “I went to the police but they didn't even ask me questions. They just took my refugee papers and tore them up. Then they arrested me, saying that I'm illegal in the country, that I don't have a paper. They put me in jail for the weekend. They told my friends to bring money so that I can be freed... And those men came every month for the money. They threatened me that they would kill me and I did it for three years” (p.44), (interview with Rwandan refugee, 30/11/1999). Notwithstanding, Tshitereke (1999) affirms that such brutality towards migrants is a result of an “intense tension and violence by South Africans towards immigrants” (p.4). Suggestions from empirical studies propose that, far from being the committers of crime, migrants have been the victims of it (McDonald, Mashike, & Golden, 1999; Triandafyllido, 2000). Despite these criticisms, the brutality of migrants remains largely undiminished, leaving them vulnerable to the locals and law enforcement officials.

In 2004, president of the republic, Thabo Mbeki requested the amendments of the act which was published in late 2005. The policy encouraged the pursuit of a binary system of limited permanent high-skilled immigration and temporary lower-skilled migration, primarily via corporate permits. However, workers in both mining and agricultural sectors were exempted from these, claiming that their periods of contract were considered as temporary work. This barred them from applying for permanent residence. The efforts by unions and human rights organizations forced the Department of Home Affairs to rethink the policy and introduce the contract periods as consideration requirements in applications for permanent resident status beginning in 1996.

Secondly, the policy laid emphasis on the retaining power within the central government services and concentrating this power within the Department of Home Affairs. This is a reflection of the 2005 strategic plan, in which the control and sovereignty as core values regulating immigration policy in South Africa is illustrated. Subsequently, the 2002 Act and its succeeding amendment were efforts at accepting these inconsistent trends without inquiring about the core components of continuity discussed above. Consequently, prospects of an externalized immigration service and state control over access to the South African labour market were rejected by the Immigration Act of 2002. It thus established the choice of incremental. This choice indicated the ANC's neutral stand towards the neoliberal opinions on which the first immigration bill was premised, which evidently associated with the General Agreement on Tariffs and Trade and the expressions of organized labour, with open remarks mainly on regional socioeconomic development and the cessation of the differential pay system were generally overlooked.

Finally in 2005, regulations adopted concentrated on discouraging illegal immigration. These regulations comprised of measures to facilitate access to permits for the region's workers

and students. It further contain restrictions intended at combating illegal immigration, such as increasing the waiting period of an individual who is married to a South African citizen to five years before applying for citizenship. This was also an attempt to curb false marriages. However, citizenship through marriage is a debatable topic as most vulnerable migrants are allegedly subjected to torture and inhumane circumstances due to their attempt to obtain a South African citizenship. Crush (2001), asserts that after passage of the 2002 Immigration Act, little was accomplished by those closely committed in the consultative process. Though the process was long (12 years) and involved a large number of stakeholders (Crush, 2001).

*South African Refugee Act (Act No. 130 of 1998)*

Chapter 5 of the above act expound on the Rights and Obligations of Refugees, specifically the protection and general rights of refugees. According to (section 27), a refugee should; (b) enjoy full legal protection, which includes the rights set out in Chapter 2 of the Constitution, the bill of rights; which preserves the rights of all people living in South Africa and affirms the democratic values of human dignity, equality and freedom and the right to remain in the Republic. In accordance with the provisions of this Act; (g) is entitled to the same basic health services and basic primary education which the inhabitants of the republic receive from time to time.

Given, the current advantages of the above act outlined in the previous paragraph, especially that of the bill of rights. It is quite predictable that migrants do not enjoy these documented entitlements. A survey done on both international migrants and South Africans regarding the history of each client's access to ART, revealed that international migrants were repeatedly denied service in the public sector, usually during the time of testing. The findings further indicated that migrants were referred to NGO sector, depriving them access to ART in the public sector as the South African identity booklets was made a prerequisite (Vearey, 2008a).



There is also, however, a further point to be considered. For example, the NSP (2007–2011) is an inclusive plan which embraces non-citizen groups (NDOH, 2007a). A key guiding principle to the successful implementation of the 2007–2011 Plan is towards it ensures “equality and non-discrimination against marginalised groups”; refugees, asylum seekers and foreign migrants are precisely cited as possessing “a right to equal access to interventions for HIV prevention, treatment and support” (NDOH, 2007a, p. 56).

*South African Immigration Act (Act No. 13 of 2002)*

Section 29 (1) of the South African Immigration Act focuses on the exclusions and exemptions of prohibited persons and further affirms the category of foreigners who *do* not qualify for a temporary or a permanent residence permit: (a). Those infected with infectious diseases as prescribed from time to time, belong in the category of prohibited persons . Of central concern therefore to this declaration, is that it did not adhere to section 27 of the South African constitution which affirms the right of everyone to have access to health care services, including sexual and reproductive health care; . It further requires the State to take reasonable legislative and other measures to attain advanced realization of the rights referred to above. However, it can be argued that advances in epidemiology, as well as treatment, rendered the above exclusion unnecessary. This counter argument is supported by the action of president Obama of the United States, who removed the 22years ban on HIV travel and immigration October 30<sup>th</sup> 2009. Subsequently, Resolution 61.17 such as the SADC Declaration on HIV and AIDS (Maseru Declaration 2003), the SADC HIV and AIDS Strategic Framework 2010–2015 and the SADC Protocol on Health seeks to provide guidance on the protection of the health of the cross border mobile population with respect to communicable diseases.

In Section 31 (1) and (2) exemptions; ascertain the persons or categories of persons who are not illegal foreigners: (2) Upon application, the Minister, as he or she deems fit, after consultation with the Board, may under terms and conditions determined by him or her (*b*) grant a foreigner or a category of foreigners the rights of permanent residence for a specified or unspecified period when special circumstances exist which justify such a decision; provided that the Minister may (i) exclude one or more identified foreigners from such categories; and (ii) for good cause, withdraw such right from a foreigner or a category of foreigners. Giving, the current socio-economic constraints experienced by African migrants with regard to the exorbitant price tag placed on permits, applications for permanent residency in South Africa are considered in terms of Section 26 (Direct Residency Permits) and Section 27 (Residency-on-Other-Grounds Permits) of the Immigration Act 2002 (Act No 13 of 2002), at the cost of 50.000. Consequently, White foreigners will be able to pay the amount leaving African migrant with less opportunities to embark on illegal cross-border activities.

Having considered the impact the permit system will have on Africans, it is also reasonable to acknowledge that On 3 April 2009, the Minister of Home Affairs announced that the DHA would issue “special dispensation permits”, under Section 31(2) (b) of the Immigration Act, affording temporary status to Zimbabweans on economic and humanitarian grounds. The temporary permit would entitle Zimbabweans to stay and work in South Africa and would be valid for a year. Depending on circumstances, it would be renewed or extended at the Minister’s discretion. The national elections and the selection of a new minister have delayed the implementation of these measures (CoRMSA, 2009, p. 36).

Additionally, CoRMSA (2009), in particular, has focused on the free visa measure. An equally significant aspect which explains how people are likely to persist in crossing the border

illegitimately due to economic and financial constraints in an attempt to obtain the three forms of identification recognised by South Africa. For example a Zimbabwean passport, an emergency travel document, or borders pass. Zimbabwean passports cost in the region of US\$670, an emergency travel document is estimated at US\$40 in the region, and a border pass legitimate for travel within a range of 20 kilometres around the border. Nevertheless though these remain a continuous challenge, The Departments of Home Affairs and of International Relations and Cooperation are allegedly seeking solutions to Zimbabwean, in an attempt to curb the passport saga by suggesting affordable mechanisms.

*The South African National Strategic Plan on HIV/ AIDS, TB and STIs (NSP), 2012 - 2016*

The NSP is a framework aimed at guiding the undertakings of all partners whose duties are relevant to HIV, sexually transmitted infections (STIs) and TB in South Africa. It is designed to make available goals and strategies for the country's approach to the three diseases during the period 2012 to 2016. The NSP will act as guide towards strategic and sector implementation plans of provincial development.

The regulatory principles of the HIV/AIDS and STI Strategic Plan for South Africa are endorsed by the Constitution, the NACOSA Plan, the Department of Health White Paper for the Transformation of the Health System in South Africa, 1997, the Comprehensive Plan, and Batho Pele. These principles comprise of: Tackling Inequality and poverty: the NSP asserts government's constitutional obligation to take rational legislative and other procedures to guarantee progressive recognition of rights to education, health care services and social security to all people of South Africa.

The HIV and AIDS interventions will be implemented in a manner through which other developments programmes will be complemented and strengthened. This is to ensure Equality and non-discrimination: The NSP is devoted to challenging discrimination against groups of people

who are marginalised. These include amongst others, refugees, asylum seekers, foreign migrants, sex workers, men-who-have-sex-with-men and orphans. The above categories have right to equal access to interventions for HIV prevention, treatment and support.

The intention of the National Strategic Plan 2012 - 2016 is to reduce new HIV infections incidence by 50% and decrease the effect of HIV and AIDS & TB on individuals, families, communities and society by enhancing access to appropriate treatment, care and support. In an attempt to form the basis of HIV, STI and TB response are the following four strategic objectives embedded in the plan. These are namely; Focus on social and structural approaches to HIV and TB prevention, care and impact; Prevention of HIV and TB infections; Sustain Health and Wellness; and Protection of Human Rights and Promotion of Access to Justice.

It is important however, to note the limitations of the above. Firstly, though South Africa has a massive roll out of treatment for HIV/AIDS in the urban areas, with accessible and reliable health systems, its rural areas suffers shortage of treatment and care, due to staff insufficiencies and infrastructures amongst others. Hence, there is an influx of internal migrants from rural to urban (urbanisation) for the purpose of pursuing better health care services and treatment. Conversely, the pull factor in the urban clinics are impacting negatively on the migrants as they are in many instances denied services based either on documents or some preconceived perception by health workers. Landau and Singh (2008) argued that one of the effects of migration is the problematic access to healthcare as “it is local governments and service providers who must channel resources to those in need, and translate broad objectives into contextualised and socially embedded initiatives” ( p. 177).

Secondly, there is a perception that the inclusion of migrant groups in ART programmes will result in a torrent of migrants travelling to access treatment (Southern African HIV Clinicians Society & UNHCR, 2007). It is important to note however, that, in order to attain the 50%

deduction of new HIV infections of the NSP; current migrant population who are infected should be included in the treatment scope. Correspondingly, results from a cross-sectional household survey piloted in Johannesburg 2008 illustrated that cross-border migrants indicated that they will go back home should they become very ill to work (Vearey, Nunez, & Palmary, 2009). Additionally, less than 5 per cent of cross-border migrants from this survey specified “ever bringing a sick relative to join them” in the country. Hence, they demonstrated that they either remit money home or travel home themselves to provide care (Vearey, Nunez, & Palmary, 2009). These outcomes contest the hypotheses that the movement of international migrants is geared towards access to healthcare services.

Subsequently, from an international human rights law perspective, migrants and mobile populations are entitled to health irrespective of their immigration status. Article 16 of the African Charter on Human and People’s Rights (ACHPR, 1986) and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1990) allow every one the right to enjoy the best attainable state of physical and mental health, irrespective of the documentation they do (not) hold (IOM,2013). Failure to provide care to migrants at an early stage of illness might cost the receiving government more to treat and care for them when the illness becomes chronic. Evidently, empirical studies conducted on migrants employed in South Africa on construction, domestic work, fisheries and informal cross-border trade. The findings rolled out migration as a risk to health under normal circumstances, but concluded that those circumstances surrounding the migration process, predominantly lack of legal status, can increase the vulnerability to ill health (Vearey, 2010; Vearey, Palmary, Nunez, & Drime, 2010)).

## **2.4. Youth sexual behaviour and acculturation**

Empirical studies have identified Sexual activity and abstinence Sex and particularly unprotected sex, as the most common risk behavior youth engage in. The Youth Risk Behavior Survey in 2007 projected that 47.8% of high school students in the U.S. have had sexual intercourse (CDC, 2008). Disaggregating this data by ethnicity, a higher percentage of Black high school students have had sex (66%), comparatively, Latinos (52%) and Whites (43.7%). In the needs assessment, Identity, Inc. found that 49% of their sample of 1,114 Latino youth were sexually active, or had already experienced vaginal or anal sex (Uriburu & Kattar, 2006). Of these, 88% had their first vaginal or anal sexual experience by age 16.

Condom use and other contraceptive is a complex behavior that is strongly influenced by the individual's beliefs about contraception effectiveness (Gilliam, Warden, Goldstein, & Tapia, 2004), beliefs about ethics and social approval (Leonard, Chavira, Coonrod, Hart, & Bay, 2006), knowledge about methods (Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006), and the length of their romantic relationships (Harvey, Henderson, & Casillas, 2006). These barriers are always present among youth, particularly migrants who basically have less information, less access to condom and exhibit greater concealment around general contraception use. However, condoms are the contraceptive method most youth utilize.

According to Denner ( 2004) the Latino culture is branded by traditional gender roles that encourage sexual tolerance among males but sexual restriction among females. This is due in part to the concepts of machismo and marianismo which govern the traditional Latino culture. Machismo is the correct masculine way to behave, which is habitually related to drinking behavior and risky sex (Galanti, 2003), while marianismo are those set of values of female purity and sexual ignorance personified by the image of the Virgin Mary (Denner, 2004).

Young Latino adults admit that they learned traditional gender roles from their parents, usually at odds with the conventional American culture (Raffaelli, 2004). The literature has steadily found that acculturation, measured either by language fondness or cohort, plays an important role in the level of sexual action and risk taking amid Latino adolescents. Latino adolescent males are at a higher risk of engaging in sex than females (Edwards, Fehring, Jarrett, & Haglund, 2008).

Nonetheless, according to Upchurch, Aneshensel, Mudgal, and Sucoff McNeely (2001), when acculturation is taken into account, there is little difference between more acculturated males and females regarding their sexual behavior. Suggesting that, more acculturated youth, irrespective of gender, have more tolerant or nontraditional values about sex than their less acculturated peers. Conversely, young Latinas, particularly those born in the U.S. are progressively negotiating their own form of femininity. Though they respect their parents' wishes of conservative sexual customs, yet defy their opinion that sexual freedom equates promiscuity (Denner, 2004). A study piloted by Bourdeau and colleagues, found that Latina adolescents were more confident than their male peers in their professed abilities to initiate sexual contact and request respect from their partners (Bourdeau, Thomas, & Long, 2008). Few acculturated Latinas from the first generation tend to have higher levels of conventional gender roles (favoring childbirth), are more likely to initiate sexual relations at an older age (after 16), and feel more invulnerable to sexually transmitted infections (STIs) (Kaplan, Erickson, & Juarez-Reyes, 2002; Newcomb & Romero, 1998; Unger, 2000). The above group also has fewer sexual partners in their lifetime (Edwards, Fehring, Jarrett, & Haglund, 2008). Contrarily, more acculturated Latino women are more likely to partake in risky behaviors, such as having multiple partners and starting their sexual life before the age of 16 (Kaplan, Erickson, & Juarez-Reyes, 2002; Newcomb & Romero, 1998).

Exploring characteristics of young people's relationships as predictors of contraceptive choices are these emerging group of researchers (Ford, Sohn & Lepkowski 2001; Howard et al. 1999; Katz et al. 2000; Ku, Sonenstein & Pleck 1994; Kusunoki & Upchurch 2008; Manlove, Ryan & Franzetta 2007; Manning, Longmore & Giordano 2000), but their work have essentially been limited to the United States context. The present study explores the attitudes, subjective norms and perceived behavioural control of migrant youth in Cape Town South Africa in relation to condom use.

## **2.5. Migration and reproductive health behaviour**

A number of studies have established that internal migrants and their partners at home are predominantly at a high risk to contract HIV (Collinson 2009, p. 9, p. 10, Kahn et al 2003, Lurie 2004, p. 2). According to (Lurie 2003, p. 2), of the 260 men and 228 women from two rural districts in the KwaZulu-Natal province, the study established that the occurrence of HIV within migrants and their partners was suggestively higher at 24% than among non-migrants and their partners at 15.0% between 1998 and 2000. The findings from other studies clearly confirm that international migrants report moving to South Africa for economic reasons, or to escape persecution; these individuals do not report migrating in order to access healthcare services (CoRMSA, 2009). An equally significant aspect of HIV transmission is disclosure, based on (personal experience, 2004-2012), most of my local female clients married to migrants tested HIV positive with CD4 counts lower than 200. Contrarily, after convincing their partners to test on the basis that their spouses test came out inconclusive, most of these migrants tested negative. Given, the current high profile debate with regard to migrants' reproductive health, it is quite important not to generalize small scale studies conducted in specific space and time.



In South Africa, the internal and international impact of migration is evident in the expenditures on services reflected beyond food and education, which has reduced the need for children to seek employment (child labor). The above factors seem to minimize the negative effects of an absent parent (Lu & Treiman 2007). However, the migration of women does not adversely affect the probabilities of child survival. This occurs despite strong structural restraints at macro levels, despite strong structural restraints; HIV/AIDS mortality and poverty disrupt families at the micro-level, (Collinson 2006). Though the exact reason is unknown, this will influence attitudes, beliefs and perceived behavioral norms of migrant youth as they join their families in the receiving countries.

Bärnighausen et al (2007, as cited in Vearey 2010) established that even when controlling for factors such as education, income or age, the risk for internal migrants becoming infected with HIV is almost double that of non-migrants. Roux and van Tonder (2006), assertion on the perceptions that internal migrants have about their own health, is based on the 2000 South African Migration and Health Survey, which establish that less than half of the migrants believed that their health situation was enhanced after they migrated (Roux & van Tonder 2006). 40% of men were less likely to think so than women. About 40% of urban-urban migrants' specified better medical access post-migration. Notwithstanding, 71% of rural-urban migrants stated that medical access was better. Conversely, (Vearey, 2011) argued that increased health risks for migrants are not due to migration as such, as most migrants are likely to be young at a productive and healthy age.

The occurrence of HIV among women with non- migrant spouses/partners is less than that of women with migrant partners. In instances where the male partner was the migrant and the female partner stayed at home, empirical study indicated that in 1/3 of these couples, the woman was infected while the male migrant partner was not. Further investigation is needed to explore

the bases of this particular discordant trend. It might however, be the outcome or combination of factors at micro level reelecting on personal choices relating to sexual relationships and condom use. At the meso level, with reconfigurations/disruptions of broader social and sexual networks and community settings. Finally at the macro level, poverty, overall levels of infectious disease, lack of access to proper shelter, sanitation and access to healthcare are predominant. Though migrants are legally entitled to access health facilities, conversely there has been a reported increase of abuse and discrimination by hospital staff (Vearey & Nunez 2010, Landau & Wa-Kabwe Segatti 2009).

## **2.6. Subjective norms related to sexual activity and contraceptive use**

The decisions of a youth to engage in sexual activity and in using effective contraception are informed by people close to them (parents, peers, church and teachers) who also influence other decisions in their lives (Hutchinson & Montgomery, 2007; Resnick, Bearman, & Blum, 1997). This section reviews the Latino culture and the crucial role parents play in the sexual decisions of their children according to rooted traditional values in familism, machismo and marianismo, (Raffaelli & Ontai, 2001; Up church, Aneshensel, Mudgal, & Sucoff McNeely, 2001). Nevertheless, certain studies recommend that traditional views on sexuality are shifting among the migrant population as well as Latinos living in Latin America.

Current qualitative studies on Mexican migrant fathers from urban and rural areas of Mexico established that fathers were less worried about their daughter's premarital virginity and more concerned about their daughters' wellbeing, integrity, and dignity. Initially, fathers from Mexican urban and rural areas displayed different views regarding sexuality, with fathers from the urban areas exhibiting more radical views as opposed to fathers from rural areas. Nevertheless, fathers from categories in U.S both expressed concern for their daughters' security

though in urban areas, young females are more exposed to physical and sexual violence, with a possibility for dating a drug dealer or gang member, and a higher incidence of STIs and unintentional pregnancies (González-López, 2004). According to Giordano, Thumme and Panting, (2009), Honduran mothers in Honduras, would like to propose to their daughters unconventional advice as they mature. When probed about the visions and expectations they have for their daughters, these women desired their daughters to display more confidence, be independent before marriage, and request equal opportunity of gender roles in marriage.

Nonetheless, these mothers would encourage their daughters towards childbearing at the right time in their marriage and the importance of delaying sexual relations to avoid being trapped in a relationship or having an unintended pregnancy. These studies suggested that parents should allow their children to make accountable choices and to protect themselves, instead of pushing their daughters to engage in abstinence until marriage, but hoped that Parental norms may be relevant in reducing sexual commencement and early conception if parents talk to their children about their hopes for their children's future and how sexuality can upset them (Liebowitz, Calderón Castellano, & Cuéllar, 1999).

Communication is an important mechanism needed by parents and children as a step to decrease sexual risk elements. Trejos-Castillo and Vazsonyi (2009) affirmed that maternal communication was connected to less sexual risk taking behaviors, though, Latino parents are not communicating to their children. The intention by Honduran women to communicate their hopes and dreams to their daughters as expressed in the focus group expressed study did not actually take place (Giordano, Thumme, & Sierra Panting, 2009). According to Gilliam, 2007a and Raffaelli, (2004), Latina mothers are confident in their social environment and culture to efficiently convey traditional opinions of behavior and morality to their daughters, but they do not discourse it. Parents enforce firm dating rules and stressed on preserving a respectable image of

one's self in the community as a way to diminish sexual behaviors in their daughters (Raffaelli & Ontai, 2001). Conversely, Gilliam argues that, Latina adolescents desire to have open conversation about sexuality with their mothers (Gilliam, 2007a) as an alternative rather than indirectly learning about their prospects (Raffaelli & Ontai, 2001).

## **2.7. Theoretical Framework**

This study will utilize both the Theory of Planned Behavior (TPB), the Theory of Reasoned Action and acculturation to explore the factors associated with attitudes, subjective norms and perceived behavior (Ajzen, 2002). It is intended to guide the development of the research questions and data collection instruments. This model will help explain individual's intentions towards the development of health behavior (Ajzen & Fishbein, 1980). The TPB model is comprised of: the Theory of Reasoned Action and the Theory of Planned Behavior. Martin Fishbein, developed the Theory of Reasoned Action (TRA). This concept takes into consideration individual's attitudes towards a behavior and their perception of how people significant to them think they should act. In a later version Icek Ajzen, extended the scope of the model and this includes individual's perception or control over their health behavior. This joint model proposes that attitudes, subjective norms and perceived behavioral control, together with demographic and environmental factors, predict individual's behavioral intentions (Montaños & Kasprzyk, 2002). This study seeks to understand the above in relation to migrant youth and the use of condoms.

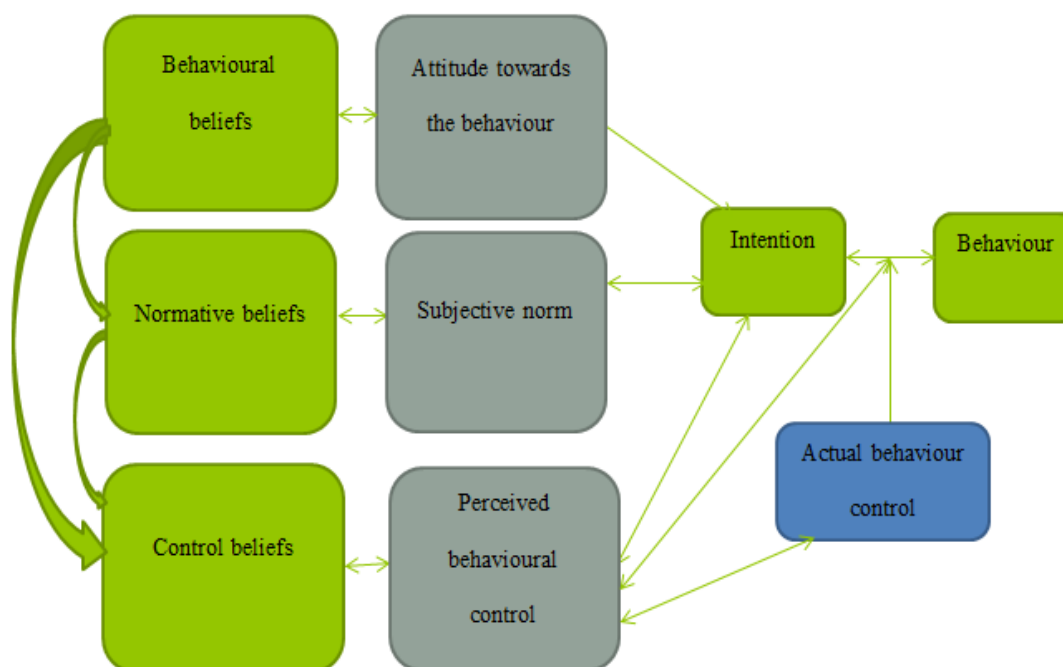
*Theory of Planned Behavior.* This theory (TPB) is a value anticipated theory where the individual, presumed to be a rational actor who weighs his or her choice toward performing the behavior based on the attitudes, subjective norms and perceived behavioral control he or she might have regarding the behavior as presented in figure 2 The determinant of attitudes can be associated to the individual's beliefs about an outcome or attributes of executing the behavior

(behavioral beliefs) based by their evaluations of those outcomes or attributes (outcome evaluations). An individual who trusts that appropriate or good outcomes are products from performing the behavior will have an optimistic attitude towards the behavior. For example, an individual who has a strong belief that condoms reduces the sexual pleasure and considers penetrated sex without condom as the ultimate outcome, will have negative attitudes towards condoms and thus less likely to use this method. Attitudes are indirectly measured by two scales: behavioral beliefs and outcome evaluation (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975).

The behavioral beliefs scale is a list of salient beliefs linked to the behavior. For example, continuing with the example of using condoms, salient beliefs might include “lack of sexual pleasure” and “effectively prevents STIs”. An individual evaluates the happening likelihood of each belief. Outcome assessment refers to the importance an individual ascribes to each behavioral belief. The individual indicates whether each behavioral belief is good or bad. Both behavioral beliefs and outcome evaluations are usually measured with (Ajzen & Fishbein, 1980). For example, an individual assesses how much her partner will approve of her using condom and whether it is important to do what her partner wants her to do.

Notwithstanding, an individual with strong normative beliefs is expected to get support to perform the proposed behavior ( see figure 1). Subjective norms are calculated by normative beliefs and motivation to comply (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). Normative beliefs are made up of a list of people vital to the individual and who impact the behavior being studied (family, friends, partner and peers).

**Figure 2 an illustratof the theory of planned behavior: Adapted from (Icek Ajzen, 2006)**



*Theory of Reasoned Action.* The theory of reasoned action (TRA) is derived from the social psychology background, and was proposed by Ajzen and Fishbein (1975 & 1980). It consists of three general constructs: behavioural intention, attitude, and subjective norm. TRA suggests that a person's behavioural intention depends on the person's attitude about the behaviour and subjective norms. The theory of Reasoned Action, illustrates a person's attitude toward behaviour. Consisting of a belief that particular behaviour is an indication of a certain outcome and an assessment of the result of that behaviour. The intention to or actual participation in a particular behaviour, will depend on the favourable outcome to the individual. Accordingly, the theory of reasoned action is an affirmation of people's intentions to perform behaviour that are anticipated from their attitude towards the behaviour (see figure 3). It further identifies the positive or negative evaluation of their performing the behaviour such as in

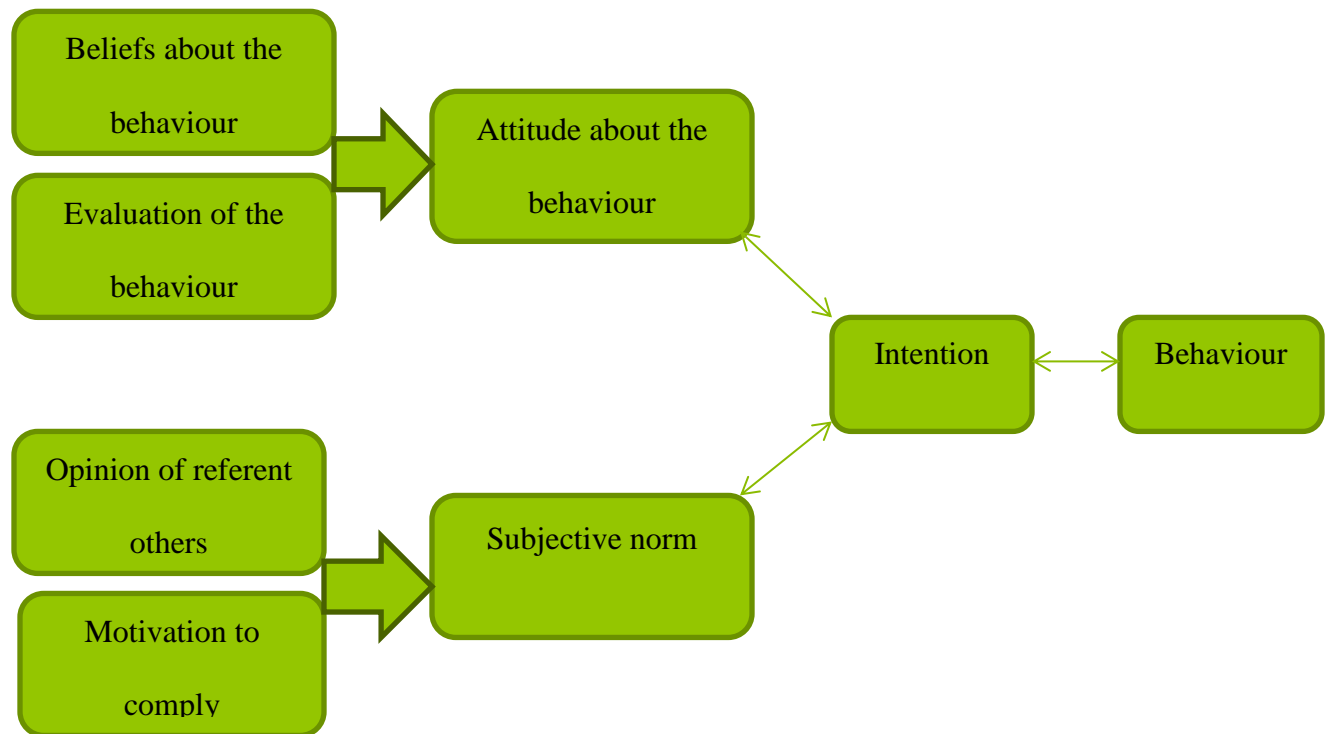
my opinion condom use is safe or unsafe. Equally, it reflects on the subjective norm. That is their beliefs about the opinion of those relevant to them, as indicated in figure 3, also contained within one's attitude toward behaviour is their perception of the subjective norm. Subjective norm is understood as a mixture of opinions from relevant individuals or groups along with goals to comply with these expectations. Seemingly, the perception of an individual towards the people who are important to him or her and what they think about his /her ability to perform the behaviour in question (Fishbein & Ajzen, 1975). Therefore, in accordance with figure 3, behavioural intention measures a person's relative weight of intention to execute behaviour.

Fishbein and Ajzen (1975) argue however, that attitudes and norms are not subjected equally in envisioning behaviour. "Indeed, depending on the individual and the situation, these factors might be very different effects on behavioural intention; thus a weight is associated with each of these factors in the predictive formula of the theory. For example, you might be the kind of person who cares little for what others think. Based on, the subjective norms would carry little weight in predicting your behaviour" (Miller, 2005, p. 127).

In this study, subjective norm will be considered as is a type of peer pressure. It is important to note however, that whether or not an individual partakes or intends to partake in any behaviour is powerfully influenced by the people who surround them. These people may consist of family, friends or a peer group and church. A belief that HIV can be washed off by showering may in some instances advocate for irresponsible behaviour towards condom use and can influence one's attitude toward unprotected sexual behaviours. However, people may also be prone or not to participate in behaviour based upon their need to conform to others. In contrast, bylaws or rules barring certain behaviour may have an effect on one's attitude toward partaking in that behaviour. Strict bylaws of document identification in the antenatal clinics in the Western Cape province along with a desire to comply with the rules can lead migrants to believe that they

will be punished should they not adhere to or participate in that behaviour. They may also develop a positive attitude toward acquiring authentic documentation and a strong intention not to act otherwise. Eventually, one's attitude toward behaviour can lead to an intention to either act or not to act concerning the specific case.

**Figure 3: An Illustration of the theory of Reasoned Action: Adapted from ( Fishbein & Aizen, 1975)**



*Berry's Theory of Acculturation.* Acculturation is the process of cultural and psychological adjustment following an interaction with a different culture (Berry, 2003; Sam & Berry, 2006). The theory of acculturation is very ambiguous and complex so is its definition which varies depending on the vantage point of the discipline of the definer. The concept of acculturation was initiated as early as 1880 (Powell, cited in Herskovits, 1938), though its earliest conventional preparation can be attributed to Redfield, Linton, and Herskovits (1936).



The theory of acculturation was formerly advocated by two major disciplines; anthropologists and sociologists, while Psychologists were notably absent. Accordingly, Dyal and Dyal (1981) observed “these two disciplines, along with economics and political science, have staked out and established claim to much of the domain of acculturation research” (p. 303). Furthermore, in a broad review paper of over 145 acculturation studies by (Graves & Graves, 1974), no papers published in psychological journals were quoted. However, in a later exceptional issue of the *Journal of Cross-Cultural Psychology* on the psychological perspectives on culture change, (Berry, 1977) stipulates increased attention toward the psychological features of acculturation since “in recent years psychologists themselves have increasingly engaged themselves with a range of psychological variables which are thought to precede and stem from changes in a cultural system” (p. 131). Thus researchers in acculturation are seeing the critical, essential role of the individual in the process. Therefore, an analysis of acculturation is inadequate if studied only from the perspective of institutions (sociological approach) or cultural patterns (anthropological perspective). Berry (1980), further propagated some specific psychological variables which include; cognitive style, personality, identity, attitudes, acculturative stress, and language.

The improvement of language and articulacy is the sole communication-oriented variable in the group (Nicassio, 1985). According to Berry (1980), acculturation is perceived as adaptation, the decrease of conflict, which is conceptualized in three modes: adjustment, reaction, and withdrawal. He advocates a three-phase course to acculturation: contact, conflict, and adaptation, with contact as the core model to the acculturation process. The nature, tenacity, and extent of interaction contribute to acculturation peculiarities. Berry (1980) declares that “the least acculturation may take place where there is no purpose (contact is accidental), where trade is mutually desired, or where contact is short-lived; the greatest acculturation will take place where

the purpose is a deliberate takeover of a society (e.g., by invasion) or of its skills or beliefs (e.g., by settlement)” (p. 11)

Furthermore, Berry (1994, 1997) added two basic dimensions of acculturation: maintenance of original cultural identity and maintenance of relations with other groups. Through extension, he promotes four acculturation strategies: integration, separation, assimilation and marginalization. Integration symbolizes those individuals who value both cultural maintenance and intergroup associations. Separatists are those who promote cultural maintenance but view intergroup relations as less important. Assimilation refers to the category that rejects cultural identity and in favor of the host culture. Those who value neither cultural maintenance nor intergroup relations are known as marginalization. Fewer difficulties are assumedly experienced by those who practice the strategy of integration.

## **Conclusion**

Most of the literature rendered from outside South Africa. Subsequently, implications of the findings based on the intervention had a generalist undertone. Notwithstanding, the studies that are related to the theories in the African framework, such as Ghana and South Africa, failed to go past prognostic statistical prototypes in clarifying the effectiveness of the models. However, it is important to relate that certain findings cannot be applicable in the South African context. Nonetheless these limitations can be curbed, because it worthiness remains in a number of situations where successful models can be tested and tried in South Africa. Likewise, the sample utilized in this study (migrant youth in South Africa, aged 18-35), is contrary to the convenience samples employed by above studies. This comprised Latino adolescents, university students or clinic attendees.

## **CHAPTER THREE: METHODOLOGY**

This chapter deliberated on the research design and techniques in terms of the research objectives stated in Chapter 1. The initial phase in applying the theory of reasoned action and planned behaviour was to conduct open-ended elicitation interviews to ascertain modal salient beliefs (commonly held beliefs) and modal subjective norms (most frequently reported significant others) in the target population (Ajzen & Fishbein ,1980; Fishbein & Middlestadt, 1989; Montano& Kasprzyk, 2002). The purpose of an elicitation study was to comprehend the distinctiveness of the target population, in order to enhance interventions, modify it to their specific circumstances and make the interventions more relevant.

### **3.1. Research design**

A research design is defined by De Vos (2005) as a detailed plan of how a research study is going to be conducted. According to Babbie and Mouton (2007), a research design is a plan of action used by a researcher to carry out a study. This study adopted a qualitative exploratory design to explore and examine the challenges, experiences and barriers faced by young migrants in Cape Town, South Africa, in regard to their behavioural intentions towards condom use.

As defined by De Vos (2005), a qualitative exploratory design is focused on the meaning, experiences and understanding of people and is often adopted when exploring the perceptions of respondents about a particular topic. According to Babbie and Mouton (2007), “Qualitative research attempts always to study human action from the insider perspective. The goal of the research was defined as describing and understanding ...”, (p.53) The researcher found this design helpful in exploring the opinions, beliefs and attitudes, behaviors and motivations of the participants. The design was more appropriate than a quantitative design because it provided valuable interaction with participants and allowed a better understanding of participant’s

perceptions and interpretations of their own life experiences as young migrant in relation to attitudes, beliefs and perceived behavior to condom use (Babbie & Mouton, 2007).

### **3.2. Population and Sampling**

This section describes the population, sample and sampling techniques that applied to the study. Population in research refers to the totality of persons or human units from which a sample is drawn in order to study a particular research problem (De Voss *et al*, 2002). The study made use of purposive sampling which was a non-probability sampling method and snow balling. Through purposive sampling the researcher was able to select respondents on the basis of them possessing the characteristics that were relevant to the study to be undertaken. De Voss, et al. (2002) argue that, “a purposive sample is based entirely on the judgement of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population” ( p. 207). In this study, the purposive sample did not only target youth but specifically identified migrant youth in the 18-35 age cohort as it participants.

Furthermore, the study employed snow ball sampling or chain referral sampling. This is a non-probability sampling technique where current study participants will recruit future interviewees from among their acquaintances. Most of the available research in the field of HIV/AIDS studied student and adolescent populations such as (Abraham et al., 1999; Bolder et al., 1992; Boyd & Wanders man, 1991); this trend excluded migrant youth in Africa, especially from countries such as Cameroon and Congo. It was advantageous to extend behavioural research to the migrant youth population. Their present state of mind is a mixture of their receiving society, perceived beliefs and the interplay of policy in terms of the constitution and policy implementation in health care services of South Africa. This offered a convenient audience for the promotion of preventive health care and treatment. In an attempt to remedy this shortcoming,

the population of interest for this study was identified as being young migrants in Cape Town, South African.

In this case, 20 migrant youth, respondents comprising of 13 males and seven females were eligible for this study. These participants were considered for the study (based on their availability and acceptance to participate in the study). The advantage of adopting a purposive sampling technique was that it minimized non-response and ensured that the pre-defined characteristics of interest were explored. Its key disadvantage was that since it was not random; it did not provide the scope for wider generalization of the results and outcome (Punch, 2005).

A chain-referral sampling was drawn from communities with high rate of migrants' residents, such as Maitland and Bellville. The study was comprised of two groups of participants (married and single; male and female). These groups were targeted for participation based on their availability. All potential interviewees were contacted and briefed on the study. They also signed consent forms to enhance confidentiality. Contacts were made by the researcher and telephonically if need be.

### **3.3. Recruitment and inclusion criteria**

Francis et al. (2004) suggests that at least 20- 25 people should be used for the elicitation study phase of the research studying the theory of planned behaviour, and at least 80 for the main research. This study was the elicitation phase of the research and aligned to the requirements by recruiting 20 participants (migrant youth) for the interview, it comprised of seven females and 13 males aged 18-35 years. The participants consisted of young migrants in South Africa from two main African countries. Furthermore the sample focused on migrants who were either in school, working or planning to either enrol in school or in the process of job hunting.

### **3.4. Data Collection**

*Gaining Entry.* The researcher visited the migrants in Maitland and Bellville to obtain permission. The researcher introduced herself as a student from the University of Cape Town interested in carrying out a research on young migrants. Some of these migrants identified themselves as youth. The issue of confidentiality was clearly explained to the respondents. The researcher gave the participants a briefing on the study, its purpose, objectives and its possible benefits. Conversely, the researcher sought potential interviewees from these communities. These communities were purposefully selected because it portrayed the mixture of migrant youth of both genders and the age cohorts applicable for this study. The researcher and respondents both agreed on a convenient date and time for the interviews. The married female respondents informed the researcher to expect interruptions during data collection process as they might be attending to their babies.

Data was conducted through face to face in-depth interview as a method for collecting information. According to Punch (2005) data collection involved gathering and measuring information on variables of interest, in an established manner that enabled one to answer the research questions and hence evaluate the outcomes. Participants felt free to tell their story without the discomfort that could be experienced in a larger group, especially when sensitive issues arose. Interviews were conducted in English to enhance communication between the participants and researcher. Conversely, during these interviews, the researcher was able to get detailed information and clarification by probing. In addition, the researcher established rapport and gained the cooperation of the participants through the use of this method of data collection (Creswell, 2008). Through this method, the researcher recorded the context of the topic and also provided a platform to guide the participants through the answers. Interviews were conducted in an environment comfortable for respondents to speak, taking into consideration the sensitive nature of the topic.

The above interview schedule focused on the main research question. These questions were developed for use by the researcher to enable participants and to provide in-depth analysis on the topic. These questions were also tailored to validate the bigger study, by determining its relevance and further determine respondents' participation. According to (De Vos 2005), semi-structured interviews enabled the researcher to gain the picture of participant's perception of the topic. Brown and Dowlin (1998) pointed out that interviews enable a researcher to explore issues that are difficult to understand in detail. The researcher personally engaged a tape recorder that was used to collect data with the consent of the respondents. A full recording of the interviews between the researcher and the respondents was done and the tapes were later transcribed for analysis (De Vos, 2005). The use of tape recorder gave the researcher enough time to focus and concentrate on the interview. Pen and paper was employed for writing of extra notes from the interviews. This enabled the recording of non-verbal cues, such as a smile, laughter and shrug, which could not be captured on a tape recorder. The interview process took about an 45 minutes.

A pilot study is usually necessary in a study to try the research method on a small scale. According to Monette et al (1998) as quoted in (De Vos, et al., 2002) a pilot study is "as a small scale trial run of all the aspects planned for the use in the main inquiry" (p. 211). Five participants were recruited for the pilot test. The recording processes proved against the researcher's assumptions that women would not partake in the study without permission and presence of their spouses. During the process the participants married and unmarried were able to answer the questions separately and also offered more information. However, in the process of data collection, the researcher realized that some questions were a repetition of others and were constructed in an incomprehensible manner confusing to respondents. The numbers of questions were reduced in each section, some questions were either changed or rephrased and more propping was done during the final phase of the data collection.

The pilot study assisted the researcher to sharpen her interviewing skills and to better articulate herself during the real interviews with the study participants. Furthermore, the recorder was new and complicated to use. Some piloting data were missing. Corrections were made and a technician from the Department of Education Mr Lance was contacted for a brief preview of the recording instrument.

### **3.5. Data management and analysis**

According to Hsieh and Shannon (2005), Qualitative data analysis is defined as: “a research method for the subjective interpretation of the content of text data through the systematic process of coding and identifying themes and patterns” (p. 1281). The data was collected using a voice recorder. Data was further transcribed and analysed.

Data analysis in this research was practical using the adaptation of Tesch’s steps in coding and collecting data (Tesch, 1990 as cited in De Vos, 2002). These steps include;

- In this study, all 20 transcripts were read to acquire a sense and understanding of the entire project. The researcher further made brief notes according to the flow of ideas.
- During the analysis labels were accorded to various texts in an effort to understand the underlying meaning in relation to the objectives of the study. This was done at the margin of the transcripts.
- Major themes, categories and sub-categories were then generated from the text with the use of colour kokis (highlighters).
- The main themes, categories and sub-categories were revisited to ensure that they reflect the main objectives of the study. This was performed to verify the preliminary arrangement to classify new categories and codes that emerged.



- Further refinement of coding was done in order to arrive at coding framework that made sense of the data as most descriptive words were categorised
- The findings were written up using the coding framework as a guideline.
- Actual codes were used to illustrate the themes/categories/sub-categories and these codes were linked to various authors in the literature review.
- The researcher recoded existing applicable data and added her critical commentary in the discussion.

### **3.6. Data verification**

According to Morse, Barret, Olson and Spies (2002), data verification denotes the mechanisms used during the process of research to contribute towards ensuring both the reliability and validity of the study. In this study, the researcher verified and checked the data; errors were identified and corrected to avoid consequent subversion of the data. Furthermore, to ensure the reliability and validity of data, the researcher made sure that there was methodological consistency and sampling adequacy. This generated a dynamic relationship between sampling, data collection and analysis. Punch (2005), argues that verification of data involves the process of checking, confirming and testing for accuracy. To enhance methodological coherence, the researcher certified similarity between the research question and the component of the method.

Secondly, the sample was suitable comprising of participants (migrant youth) who embodied the research criteria and guaranteed the efficient and effective saturation for the purpose of replication. Furthermore, data was collected and analysed concurrently to create a mutual interaction between what is known and what needs to be discover for the purpose of validity. Reliability and validity can be achieved through the careful use, interpretation and

examination of literature (Carson, et al., 2001). These include the careful justification of the qualitative research methodologies employed (Carson et al, 2001). In a qualitative paradigm to ensure “trustworthiness” indicated as; credibility, transferability, dependability, and conformability (Guba, 1981; Cuba & Lincoln, 1981; 1989). The above was achieved because the participants were ethically considered.

### **3.7. Ethical Considerations**

*Ethics are a set of moral principles that are widely accepted and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondent, employers, researchers...* (De Vos, et al. 2002, p. 63).

De Vos, et al., (2002) identifies harm to subjects, informed consent, and deception of subjects, confidentiality and publication of research findings as key ethical considerations which the researcher will take into account. This study was based on oriented human subject research that was systematic in its investigation. It involved the use of human subjects in any capacity. Hence, the researcher integrated both the gathering and analysis of data in order to answer the research questions. Conversely, human subjects were important to the performance of research anticipated to improve human health. Therefore, in this study the relationship between researcher and participants (human subjects) was based on the principles of honesty, trust, and respect.

An ethical review form ascribed by the Department of Social Development in the University of Cape Town was completed and reviewed by its committee members. In accordance with its policy and human subject protection, an ethical clearance was granted for this study.

*Risk and Benefits.* The presumed risk of this study involved emotional and psychological outburst. Regarding the sensitive nature of the topic, participants' unveiled information they had buried and developed temporary coping mechanism. In such instances, the researcher referred the said participant to her supervisor who is a trained social worker to help the client. This study was expected to inform and influence on-going efforts to effectively target and support young migrants in Cape Town by clearly identifying the key challenges and constraints affecting them in making inform health preventive behavioural choices.

*Informed Consent.* According to Babbie (1995), Verdugo (1998) and Punch (2005) the researcher beforehand has to inform respondents of the general nature of the research so that they can make an informed decision regarding their ability to either participate or not. The researcher, made first contact with the respondent to avail all information verbally pertaining to the study, its purpose, main objectives as well as its possible potential. This enabled the respondents to make informed decisions with regard to participating or not in the study.

The researcher obtained consent of the participants to use a tape recorder, to capture the whole interview. This was to pay full attention to the participants and transcribing. Permission to use the tape recorder was sought at point of first contact with the respondent. A consent form was developed by the researcher and signed by each participant. On the consent form a space was created for thumb print to accommodate those respondents who were unable to write. This form enabled participants to either agree to or disagree to grant permission for the study (see appendix A).

*Voluntary participation.* Participation in this study was voluntary and under no circumstances was the subjects coerced into participation (Babbie, 1995; Burton, 2000).The

respondents were told before the interview that participation was strictly voluntary. The researcher did not coerce or used rewards to try and entice participation in the study.

*Privacy, anonymity and confidentiality.* In order for participants to open up about issues under study it was imperative that privacy, confidentiality and anonymity were maintained. This did not only assist participants to open up, it further encouraged them to shared openly knowing that what they were sharing would not be used against them and that their identities would remain protected. According to Babbie (1995) “a respondent maybe considered anonymous when the researcher cannot identify a given response with a given respondent” (p. 50). The real names of respondents were not used but pseudonyms to ensure privacy. The interview was only shared by the respondents, the researcher and the researcher’s supervisor to ensure further privacy. The researcher informed the respondents of anonymity prior to the interview. In addition before every interview the researcher made it known to the participants that whatever information was shared will remain confidential.

*Deceiving participants.* The researcher was opened and honest with respondents on issues pertaining to the study and its purpose. The researcher did not use any deceptive means to acquire information for the study. Struwing and Stead (2001: as cited in De Vos, et al. 2011) argue that the interviewer must not resort to deceptive tendencies that mislead participants, or withhold information.

### **3.8. Limitations to the study**

The limitations to this study reflected the research design, the research method, sampling method, and data collection method and data analysis. According to Babbie and Mouton (2001) in an exploratory study respondents seldom provide satisfactory answers though they may hint at

the answer. Thus participants taking part in exploratory studies rarely divert from the topics under discussion. In some occasions they might misapprehend the subject under discussion (Babbie and Mouton, 2001). The researcher was attentive and endeavoured to repeat questions to determine respondents understanding of the subject. The following are limitations to the study.

The research was limited to the perception of migrants from only two countries. This however, cannot represent the entire African cross-border migrants in South Africa. Secondly, the disadvantage of the snow balling and purposive convenient sampling method made it difficult for the findings to be generalized. Furthermore, the researcher faced circumstantial limitation while collecting data. Some participants were French speaking and the research was conducted in English, this may have affected the interview responses. While the language alleged limitation could not be discounted, there were in comparison small, when compared to overall English speaking participants. Similarly, social desirability could be another limitation encountered by the researcher during the interviews. Of central concern was the gender of the researcher (female) which may have affected the responses of the male respondents.

### **3.9. Reflexivity**

Due to the subjective nature of qualitative data analysis, it is always difficult to ascertain the extent of influence that the researcher has over the results. According to Levy and Schick (2005), "...the researcher's beliefs, values and predispositions influence the entire process..." (p. 293). The researcher endeavoured to ensure that no bias got in the way of the study by staying impartial.

The outcome of the study was influenced by the competence of the researcher. The ability to acquire information depended on how the interviewer handled the interview process. The

researcher therefore had to take it upon herself to be calm, collected, friendly, trustworthy as well as genuine during the interviews. This created an enabling environment for a fruitful interview session.

## CHAPTER FOUR: PRESENTATION AND DISCUSSION OF FINDINGS

This chapter discusses the research findings in relation to the five research objectives.

Data was analysed using a table that represents the profile of respondents and framework for analysis. To achieve these objectives, section one embarks on profiling the 20 participants as shown in table 1. The profile will include their gender, age, and marital status, level of education, type of permit, employment and country of origin. Furthermore, the framework of analysis will be conveyed in table 2, consisting of themes, categories and sub categories formulated from reading the interviews of the transcripts. This method was adopted in accordance with Teschs (1990) framework as discussed in chapter 3.

**Table 1      Profile of Respondents**

<b>Respondent (R)</b>	<b>Ages</b>	<b>Marital Status</b>	<b>Gender</b>	<b>Education Matric +</b>	<b>Permit Type</b>	<b>Years of Stay in SA</b>	<b>Country of Origin</b>
A	31	Married	Female	Postgraduate	Refugee	7	Cameroon
B	25	Single	Female	Graduate	Refugee	5	Cameroon
C	30	Married	Female	Graduate	Refugee	9	Congo
D	34	Married	Male	Graduate	Refugee	4	Congo
E	26	Single	Male	Graduate	Refugee	3	Congo
F	25	Single	Male	Graduate	Refugee	3	Congo
G	27	Married	Female	Graduate	Refugee	2	Congo
H	26	Married	Female	Matric	Refugee	4	Congo
I	20	Single	Male	Matric	Refugee	2	Cameroon
J	28	Married	Female	Matric	Refugee	7	Cameroon
K	22	Single	Male	Matric	Refugee	2	Cameroon
L	30	Single	Male	Matric	Business Permit	5	Cameroon
M	21	Single	Male	Matric	Refugee	2	Cameroon
N	22	Single	Male	No	Refugee	3	Cameroon
O	24	Single	Male	Matric	Refugee	3	Cameroon
P	22	Single	Male	Matric	Refugee	2	Cameroon
Q	23	Single	Male	No	Refugee	3	Cameroon
R	35	Married	Male	Matric	Refugee	6	Congo
S	35	Married	Male	No	Refugee	6	Cameroon
T	33	Married	female	No	Refugee	1	Cameroon

#### **4.1. Socio-demographic profile of participants**

As illustrated on Table 1 above, 20 migrants participated in this study. They comprised of seven females and 13 males. Participants were nationals of Cameroon and the Democratic Republic of Congo (DRC), of which 13 are from Cameroon and seven from DRC. The geographical location covered in the present area of study (Maitland and Bellville) have a very high rate of migrant population. The youngest participant is aged 20 and the oldest is 35 years. Of the 20 migrants, seven are female, six of these females are married while one is single. Additionally, 13 participants are men, three are married and 10 are single. In terms of educational achievements, four of the 20 migrants are without matric qualification, nine had matric qualification and seven had post-matric qualifications. All the participants hold a refugee permit status except one respondent who is a business permit holder. According to the participant's years of residing in South Africa, only one respondent has been in the country for less than three years, six have resided in South Africa between four to six years and three of the migrants confirmed a seven to 10 years stay. Although majority of the participants are educated, they are mostly employed in the security and hospitality industries as they endeavour to work and study. Nevertheless these migrants are the bread winners for their respective families back home. Conversely, the health status of these migrants is of outmost importance to them and their families.

#### **4.2. Framework for analysis**

Table 2 below presents the strategy that was used in analysing the qualitative data collected. The questions that were posed helped to bring to light different themes, categories and subcategories.



**Table 2: Framework for analysis**

<b>THEMES</b>	<b>CATEGORIES</b>	<b>SUBCATEGORIES</b>
4.4: Migrants knowledge of condom and intention to use condom	Knowledge about HIV and AIDS.	School Media , Friends
	usage of condom	Partners and Girlfriends
4.5: Attitude towards condom use	Intentions to test for HIV.	Regular use of condom Effectiveness of condom Reliability of condom
		Stimulation of sex Condom not comfortable Condom is fun to use
		Embarrassment Gender roles
	4.3.3: Purchase of condom	Trust and negotiation
	4.3.4: Identity and condom	
4.6: Subjective norms and the impact on condom use.	4.4.1: Parents, partner, siblings, peers	Value Encourage
	4.4.2: Religious leader	Expectations Compliant
4.7: Migrants perceived behavioural control	4.5.1: Ability to act on acquired knowledge	Social pressure Staying faithful to one partner
4.8: The influence of acculturation on condom use	4.6.1: Change of idea	Free access of condom
	4.6.2: Risky sexual behaviour	No cost
4.9: Barriers & challenges towards preventive health care provision	4.7.1: Lack of documentation	Free services
	4.7.2: Shortage of staff	Negative attitude and negligence

### **4.3. Migrants knowledge of condom and intention to use condom**

The knowledge of migrants in terms of condom use in this study was ascribed to; the knowledge of HIV and AIDS and the use of condom. The participants further revealed that the school, media and friends were some of those avenues where information was gained to enhance knowledge. Notwithstanding, knowledge not practiced is knowledge not acquired.

#### **Knowledge about HIV and AIDS**

To be informed is to be empowered; the level of information around the issues of preventive health has recently been promoted as a measure to help reduce the increasing cases of sexual transmissions in Africa especially South Africa. According to the analysis, all the respondents, had information about the male condom and how it is used. 1 participant claimed to have gained his knowledge from school, while the vast majority hailed the media and friends as their avenues of learning.

As I was growing up as a teenager I used to hear my friends talking about condom and I ask my friends because I was so inquisitive. Then they told me what it is all about (*28 year old, married female*).

The media is one of the avenues through which information can be transferred. Although, these networks may pervert the perception of some viewers, this study found that participants were positively influenced by the media and school.

Yes I know about condom use and I heard about it from the news, advertisement and entertainment movies (*31 years old female*).

So I know about condom since I was very young because in school they used to talk about it and on TV they used to advertise so condom is not new for me (*34 years old married male*).

According to the above respondents, the main source of information is the media and friends. These alleged sources are usually flawed in terms of the level of right or wrong information imbedded in their messages. Right learning will propel one towards positive behavior while negative learning will have an adverse effect. Notwithstanding, The National Strategic Plan 2012 – 2016, ranked young people as a high-risk group and aims to decrease the occurrence of new HIV infections by 50%, through information gained. However, without continuous correct information these statements of intent written on policy document will not be evident in the lives of youth especially young migrant. Nonetheless, beliefs about ethics and social acceptance (Leonard, Chavira, Coonrod, Hart, & Bay, 2006), awareness about procedures (Sangi-Haghpeykar, Ali, Posner, & Poindexter, 2006), and the duration of a said relationship (Harvey, Henderson, & Casillas, 2006), will impact on knowledge acquired by these migrants and their ability to translate these information into the usage of condom.

#### *Usage of condom*

The use of condom is promoted as one of the key HIV prevention methods in South Africa, to curb the rate of transmission. In this study, respondents who are single indicated high rate of condom usage while those who are married had little or no condom use experience. All single respondents all confirmed the use of condom. While half of the married participants agreed to its use. Conversely, most of the single respondents also talked about not using condoms with other partners but using with girlfriends. In this context, partner is attributed to a

long relationship, while girlfriends refer to a one night stand, temporal girlfriend or multiple partners.

Yes you see that depends with my partner I don't intend to use condom because I know her health status and I am not scared about pregnancies for her but with another girl we will use condom *(22 years old single male)*.

If I have sex with multiple partners that is when condom will come in but if I have sex with my partner whereby we both know our status I think condom can only come in if we decide upon *(30 years old single male)*.

The following 35years married respondent who according to findings is ignorant of his wife's HIV status have this to say about the use of condom.

Impossible I can't have sex with my wife with condom I don't think I will like to use condom with my partner so the use of condom is out of the way for me *(35 years old married male)*.

Although the above display a high knowledge and usage of condom, it is important to note that the act of sex is a private issue and one can only agree to what is shared publicly. However, their acceptance of multiple partners is high risk behavior. The CDC (2008) projected in accordance with the Youth Risk Behavior Survey in 2007 that 47.8% of high school students in the U.S. have had sexual intercourse. Equally, the researcher in the current study found that Migrants portrayed more risky sexual behavior than those in the US. Yet, intentions are expected to capture the motivational factors that impact on behaviour; they are pointers of the length through

which an individual is willing to try, the extensive effort he/she is prepared to exert and perform the behaviour (Ajzen, 1991).

#### **4.4. Attitude towards condom use**

Attitude ascribed to a multifaceted mixture of things that forms an individual's behaviour, such as; personality, beliefs, values, behaviours, and motivations (Fishbein & Ajzen, 1980). Conferring the findings of this study in relation to migrants' attitude towards condom use, the researcher established that; intention to test for HIV; pleasure associated with condom use; purchase of condom and identity and condom where consistent with their revelations. However, the above could not be separated from their sub categories stated in table 2.

#### **Intentions to test for HIV**

The intentions to test for HIV depends on an individual's ability to develop and act on his or her cognitive elements (beliefs and values), feeling element (attitude) and behavior (actions, decisions and intentions) in the process of time and space. The research findings revealed that majority of the participants had tested for HIV in the last 12months, one participant had not tested and few have tested in the last five years. The outcome of testing for HIV underpinned the concepts of: regular use of condom, effectiveness of condom and reliability of condom.

Yes we went to do HIV test couple of months ago in the clinics (34  
*years old married male*).

Mmm I already took one that was in August last year I got no  
problem with that (28 *years old single female*).

The research found that while participants professed a good knowledge of HIV and AIDS, some struggled with the right information about testing and the three months waiting period (window period).

Ah I am planning because the last time I make an HIV test it is like six months so I am still afraid may be the virus did not come out that time because usually we do HIV test every three months so now it is like six months so I am still doubting myself so I know I really need to know my status (*22 years single old male*).

When I wanna get married in the future I and my partner will go for an HIV test (*21 years old single male*).

Contrary to the perceived cultural notion that men do not visit the clinics and only test late when HIV has progressed. It is important to note however, that the male participants of this study displayed an interesting twist in this dialogue of testing. Almost all the men except for one have tested while all female participants also tested. The reason for the high testing rate for men could be attributed to their knowledge and fear of South Africa's high rate of HIV infection. This is what one participant had to say:

I had sex using condom and ok tested because before we came to this country we were told about there too much STDS like there is too much HIV in this country (*22 years old single male*).

Despite these enhancing feedbacks, recent studies on youth in South Africa have found that youth aged 15-24 years are increasingly becoming vulnerable to HIV (Department of Health 2005). Thus need to be encouraged to use condom regularly.

### *Regular use of condom*

The spread of HIV and AIDS in the West (Europe and America) through sexual conduct has been curtailed and reported cases are mostly through infected needles. On the contrary, in Africa, HIV and AIDS is mostly transmitted through unprotected sex. It is therefore imperative that regular use of condom becomes a lifestyle. The findings portrayed that participants' regular use of condom is advanced.

Yah I use a condom regularly because there so many diseases out there until after you get married and you both know your health status *(21 years old single male)*.

Yes regular use when it is not my partner that is a new girl or someone who is not my partner whom we have not tested together. But if it is my partner like wife to be and we have tested I will not use it all the time *(22 years old single male)*.

The below respondent portrayed that the (male) condom is a male dominated protective measure where the man dominates even in the bedroom.

I would use condom during intercourse but not regularly because I am a married woman there are times I would want to have children or just have fun or my husband might reject it well just like I said before as a married couple I don't think it is wise to use condom. Unless I am infected then I will use it regularly for protection *(31 years old married female)*.

However, females are still subjected to male domination. This is evident in the above respondent where the husband can reject the use of condom on gender basis. Kashima, Gallois and McCamish (1993) suggests that since condom use is less an individual than a joint behaviour as it entails the collaboration of a sexual partner. Bearing in mind that individuals are uniquely different, it will also reflect on their intentions concerning condom use. In this study, intentions attained from one partner may not project their joint behaviour.

#### *Reliability of condom*

Half of the respondents indicated that condoms were the reliable while the other half indicated that they were not safe. Interestingly, some participants equated condom reliability to its free distribution in South Africa.

It is reliable because it reduces illness and death rate (25 years old single female).

Condoms are reliable like let me say like here in South Africa most condoms is for free they give for freely. The rate of HIV is too much (24 years old single male).

While others defended the fact that condom are in some cases are very unreliable. This could be attributed to knowledge in terms of use. The following respondents had these to share.

Very very unreliable 55% in fact I got a scenario where by I myself I nearly fall a victim where by a condom that was properly fitted in but before I realize everything was out (30 years old single male).



I have been using that on my previous life but it didn't help me most of the times condom was broken inside of me and I will find it later after two days I will find myself in the hospital and they are taking that piece of condom out. It didn't help me *(26 years old married female)*.

Condom use involves, having access to it and owning it as well as the opportunity of having a potential sexual partner. These elements are assumed to impact on the connection between intentions and behaviour (Liska, 1984) and this will accord findings influence the usage of condom.

#### *The effectiveness of condom as a birth control method*

The effectiveness of condom as a birth control method was another issue that was investigated by the research. And migrants showed relevance to the findings. From the data collected, most respondents testified to the effectiveness of condom as a birth control method, whereas 1 respondent indicated otherwise.

Condom is good in like birth control method because if you must plan if don't wanna have a baby now, organize if you can have 4 years baby now you and your partner can plan from the time that your partner put to birth. From there you can start using condom *(25 years old single male)*.

The above respondent affirmed to the effectiveness of condom as a birth control method. Coming from a male it is interesting to understand the shift as indicated in the findings in both information and practice of birth control among the young acculturated generation of migrants. Although condom use and other contraceptive is a complex behavior that is strongly influenced

by the individual's beliefs about contraception effectiveness (Gilliam, Warden, Goldstein, & Tapia, 2004), some migrants like the following participant attested otherwise. Reasons for this may be attribute to preconceived perceptions or unexplained mishaps.

To me birth control method I don't think so because sometimes the condom is not effective, not capable of doing the job it was meant to do they say condom burst or condom was not fitted nicely or perfectly or the other way around (*22 years old single male*).

Despite the negative feedback from the above, the male condom remains the sole method that can be used both as a birth control method and a preventive measure from diseases (WHO, UNFPA &UNAIDS, 2004).

#### *Pleasure associated with condom use*

Sex is an intimate act between two or more partners and this is usually associated with pleasure. In this context, sexual intercourse is between two partners of the opposite sex. According to the data collected, majority of the respondents do not obtain pleasure with condom during sex, while 1 participant felt otherwise. Their reasons are interrelated to; stimulation of sex and condom not comfortable or fun to use.

Yes I do find pleasure when I am using condom but some people say when you using condom it seems as if you are doing artificial thing but condom is the same whether you are using it or not (*23 years old single male*).

### *Stimulation of sex*

Sex without stimulation is usually painful with or without condoms. It necessary for both parties involved to understand the act of romance before intercourse. This according to the findings was to some extent absent in the respondents relationships.

No it does not err help to simulate sex like I said before not like without condom because it like flesh to flesh (22 years old single male).

Err condom stimulate sex not at all but you have to do it if you want to stay alive or HIV free (30 years old single male).

The sentiment expressed by the respondent below indicates an insight of romance before sex to enhance stimulation. However, the young male is of the notion that romance is a woman's job not a man.

Actually some people can say condom cannot stimulate sex what I can say is that if your partner moves you that much I don't see anything wrong in using condom (26 years old single male).

### *Condom comfortable or fun to use*

The proper knowledge of condom use determines whether it is comfortable or fun during intercourse. This involves the ability to; determine its expiring date; method of opening the package and the manner in which to insert the condom. During the interviews most participants

claimed to understand this but were actually lacking in these aspects identified during the demonstrations process.

Actually at times it is uncomfortable for the other party but for me I enjoy using it and I will continue using it until I get married to my wife. Before I get married I will go for test with my wife (*22 years old single male*).

Generally everything has its bad or good side but in satisfaction for sex condom is disturbing but we just use it (*21 years old single male*).

During the interview process, it was noted that most of the respondents could not separate romantic play from sexual intercourse. The inability to separate these will lead to the problem of stimulation. However, the comfort of condom will depend on the individual in relation to either the texture of or the condom lubricant. This will intern increase its effectiveness and preventive capacity. According to the UNAIDS (2004), the effective advancement of condom use as part of an inclusive HIV prevention model devoted on behaviour change is certain to decrease HIV

### **Purchase of condom**

The act of buying a condom in Africa is still coated with cultural patriarchal basis which leads to embarrassment. In this study, all 13 male participants attested to buying condom, of the 7 female participants, 1 had actually bought a condom.

As for me I prefer buying it and feel very comfortable buying. For a woman this impression that we have that this lady buying condom is she a prostitute or how is not true because she has the right protect herself (*22 years old single male*).

If a woman is seen buying condom people will look at her like she is a prostitute but for me I will look at it normal because she can also buy a condom (*24 years old single male*).

The idea of condom purchase is strongly linked with empowerment, though culture cannot be ruled out. It is culturally accepted in certain areas for men to buy condom not women. A woman buying condom is perceived as morally indecent. However this ordeal has created an atmosphere of fear even to some men. This is what a male respondent had to say.

I will be very ashamed to stand and buy because the person you are buying from will obviously know what you are going to use the condom for so usually send somebody to buy for me because I am ashamed to buy it (*22 years old single male*).

However, according to theory of acculturation, migrants are likely to through integration adopt the culture of the receiving country which in this study encourages the purchase of condom.

It depends the area where you err mm in South Africa condom is very common it like cigarette or buying bread (*34 year old married male*).

Empirical study has steadily found that acculturation, measured either by language fondness or cohort, plays an important role in the level of sexual action and risk taking amid youth.

Nonetheless, the extent of sexually transmitted infections (STIs), awareness of contraceptives and contraceptive use are essential indicators of sexual health among youth (Dann, 2009). Shisana et al (2009), projected an estimated 10.9% prevalence rate of HIV/AIDS in 2008, more young women are infected than young men. According to the migrants in the current study, they are now experiencing an increasing usage of condom due to its free access.

### **Identity and condom**

Participants were asked how they would identify a man or woman who suggests the use of condom. All the men affirmed to an upper urge to suggest and negotiate condom use. Though most of the female respondents felt it was difficult, majority of the male participants claimed they would be surprised if a female suggest or negotiate it use but will embrace the idea though trust is an important ingredient in this discourse.

To me I will say 80% is that she doesn't trust me and 50% is that she wants to be safe (*20 years old single male*).

I yes I will be angry if she proposes it now when we have been using without condom it means she suspects me of something or she caught me some where I will like to know first (*23 years single old male*).

As simple as it may sound, negotiating the use of condom is usually a traumatizing ordeal for most African women especially those who are economically dependent on their spouses. This in most cases may lead to the question of trust as professed by the above respondents. Accordingly, in the Latino culture where traditional gender roles encouraged, male are sexually tolerant as compared to the females (Denner, 2004), thus infusing superiority of men in the bedroom.

Like a man if I suggest the use of condom I think that we must use  
the condom (*25 years old single male*).

Condom use negotiation is the main obstacle to contraceptive use, Fisher (1990), advice that the use of contraception should be discoursed before sex. However, empirical study by Chervin and Martinez (1987) found that 26% of college students communicated the use of condom before sex. In the above findings communication before sex is rare as the men assumed that their girlfriends are not allowed to negotiate it use.

Religion also plays a significant role in condom negotiation. Most Christian believes it is pointless to negotiate condom use. This is also based on the notion of trusting one's partner:

You see me I am a Christian. I don't believe in condom and we  
don't use it. I am not saying that those are using are wrong but not  
for me (*30 years old married female*).

Me I trust my husband I don't wanda wanda outside I am a married  
woman so I need to have only one partner. Now where will the  
condom be I trust him I know he cannot make it outside (*26 years  
old married female*).

The theory of Reasoned Action, illustrates a person's attitude toward behaviour. The intention to or actual participation in a particular behaviour, will depend on the favourable outcome to the individual. In this case the intention not to use condom is based on migrants' Christian belief and the outcome is that they stay faithful. However, the concept of 'faithfulness' is complex and should be graded accordingly, taking into account the freedom to act otherwise.

#### 4.5. Subjective norms and the impact on condom use

Subjective norms speak something relevant in the life of an individual which have the capacity of influencing their behaviour positively or negatively. The following were listed as the most important people in the lives of the migrants in this study; parents, partners, siblings and friends. In this study, majority of the respondents established that their parents and partners will portray a positive attitude towards their willingness to test for HIV and comply with condom use.

My parents, yah my parents will be happy because they will know that I am interested In my health and wellbeing because they will know that I am conscious in the fact there is sickness out there and I am fighting against that *(23 years old single male)*.

If I can be happy for my partner to test for HIV so they will be happy for me because it is a way of preventing the disease to from spreading in the family and within the family if I get to know that I am positive *(31 years old married female)*.

There were contradictory responses as participants relate their friends' ability to influence their behavioural intentions. They ventured that friends will encourage performing a particular behaviour they also practice. Meaning a friend who uses condom cares about you and will definitely lure you towards its use and those who do not will act otherwise, yet they also feared stigmatization. Interestingly, the decisions of a youth to engage in sexual activity and in using effective contraception are informed by people close to them (parents, peers, church and



teachers) who also influence other decisions in their lives (Hutchinson & Montgomery, 2007; Resnick, Bearman, & Blum, 1997).

Some will be happy and some will not be happy, we all have our opinions. Those who will accept if I use condom are those friends who care about me and will even force me to use it. The others will definitely discourage me because they also are not using it or they don't love me and want me to may be fall a victim (*21 years old single male*).

Some of them will advise you to use condom and a couple of them will not see it that way because they don't use it (*24 years single old male*).

Some friends will out rightly view those who do not use condom as condemning themselves to death. The next respondent affirmed this below.

I think you know they will think that you are heading towards your grave because you will be doing it with somebody you don't even know (*20 years old single male*).

The next participant felt it is important to keep one's intention for an HIV test private and unknown to those important in their life. Fisher (1990) attested that, keeping private and unknown from those you love and care may interfere with contraceptives intentions. However, one participant skeptical about stigma associated to a positive HIV result relates below.

I think you going for an HIV test needs to be your privacy because if you know that this person is infected with HIV you will see their interaction with that person will change so I know that your HIV status is your privacy you don't need to share it with others (21 year old single male).

The religious leaders in this study have a significant role to play as all participants professed their Christian background and regular church attendance. It is popularly accepted that the church is one place where the presence of GOD is and here is where migrants find hope, help and in some cases partners. Hence, the preaching of the pastor or doctrine is very vital. Similarly, in some cases as indicated by the respondents the voices of pastors usually echo the teachings of parents.

It something that our religious leaders are dealing with severely you don't need partners but one partner because even in the Bible as a Christian you get married to one wife not wives (20 years old single male).

I think as for my parents they will always encourage one partner and my pastor also will encourage one partner (22 years old single male).

I think from where I am coming from my parents will be very happy for me to get one partner that they know. As a young person

you will face many challenges but it is good to keep only one partner *(30 years old single male)*.

Like the above migrants, young Latino adults admit that they learned traditional gender roles from their parents, usually at odds with the conventional American culture (Raffaelli, 2004). Studies on Mexican migrant fathers from urban and rural areas established that fathers were less worried about their daughter's premarital virginity and more concerned about their daughters' wellbeing, integrity, and dignity (González-López, 2004). Interestingly, most of the male respondents, who also happen to be Christians shared their inability to practice the pastor's teachings.

Pastor expects you to have one partner but the Bible says go into the world and reproduce *(21 years old single male)*.

Pastor will normally encourage one partner but I don't really do that I have one girl friend but from time to time may be you go for a bear and you just hook with a girl up for a one night stand *(22 years old single male)*.

Participants displayed an understanding of the faith based principle; one man one woman. It is important however not to assume the applicability of this beliefs in all cases.

We will get there one day you, but as young ones we are mindful of the fact that one man one wife just that for now we are still young you know *(23 years old single male)*.

Fishbein and Ajzen (1980) argue, however, that attitudes and norms are not subjected equally in envisioning behaviour. According to the findings, it could be said that control beliefs were constantly found across behaviors in the situational and internal aspects. However, parents' norms increased the intentions of single males to use condom. For the females' participants, few factors were noteworthy. Their partner's norms to some extent positively influenced their intentions to use condom. The findings also seem to indicate that religion had a role to play in shaping people's behavior regarding their sexual behavior.

#### **4.6. Migrants perceived behavioural control**

Perceived behavioural control is the extent, to which an individual feels able to perform behaviour. Findings portrayed that, migrants perceived behavioural control is underpinned by the ability to act on acquired knowledge.

##### **Ability to act on acquired knowledge**

This study found that the extent of respondents perceived behavioural control towards their ability to act on acquired knowledge was associated faithfulness to one partner and social pressure.

##### *Social pressure*

Encouragingly, all single respondents affirmed their ability to control their sexual behaviours and act upon the intentions by refusing sexual intercourse without condom. However majority, confirmed that this can only be enacted with a girlfriend (one night stand, temporal girlfriend) not a partner (long relationship). Contrarily, the only single female respondent exercised a strong control of her action irrespective of the person involved.

Yes it is possible I have done so I was in a situation where I was about meeting a girl and she said she doesn't want that thing and I saw her as someone who has been having sex without condoms. So I saw her as unsafe. So I didn't do it (*21 years old single male*).

I have done it many occasions I was in a situation in that hotel I was hoping they will offer us condom but it was not so and the lady was so hungry for sex I told the lady if there is no condom we will stay like that and definitely we stayed like that. Because I don't want you or to you give me that disease or me to say that so we will stay like that (*30 years old single male*).

Although the following professed a good control of his behavior; there is an inner male domineering aspect which according to findings did not attest to communication.

Ah I can refuse sex without condom if I want to because I cannot meet a lady for the first time and have sex with her without condom I will tell her to put on her clothes and leave (*22 years old single male*).

Subsequently, we should also consider the only single female participant who displayed a strong control of behavior based on safety and the consequences aligned to risky undertaking.

Firstly the main thing that will come into my mind is the after effect of having that sex without a condom, not using condom so I will be able to say no *(25 years old single female)*.

*Staying faithful to one partner*

Although most participants laughed at the idea of staying faithful, they expressed the desire to practice it in the future. Majority of the unmarried respondents were not faithful to their partners. However, few unmarried males and only single female in this category attested their ability to stay faithful.

That I will not be proud to say err it difficult you know to be faithful because sometimes I do some ugly stuff out there you know but I will like to practice it *(30 years old single male)*.

It is not easy for we youth because we have temptations everyday too much temptation with the opposite sex *(22 years old single male)*.

Faithfulness is a relative concept and many struggle to adhere to its underpinnings. The next respondents confessed their strong capacity to stay faithful to one partner based on their Christian faith or love. This is what they said.

It is easy for me to have only one partner, firstly I am a Christian and since I am a Christian, it will be easy *(25 years old single male)*.

As a young person it is difficult but you can keep it. That is if you really love *(25 years old single female)*.

Taking into account social pressure and the community, idleness is another factor that influenced unfaithfulness as explained the following respondent.

I think I it is possible for a Young man to stay with one partner but it depend in the community he is, friends and the activities he is involved in. The communities like ours you see young girls around who are always dressing with short skirts it not easy it is tempting, but if you are busy also working you come back you are tired you will not be seeing all those things *(23 years old single male)*.

Whereas the theory of planned behaviour (Ajzen, 1991) advocates that the performance of behaviour is subjective to the degree of personal control an individual has over their behaviour. In essence, when an individual perceive little control over the behaviour due the lack of internal and external facets such as, skills, knowledge and willpower, then their intentions to perform becomes low, though they possess favourable attitudes and subjective norms toward it (Ajzen & Madden, 1986).

#### **4.7. Acculturation and condom use**

Acculturation is the process of cultural and psychological adjustment following an interaction with a different culture (Berry, 2003; Sam & Berry, 2006). Under acculturation and condom use the respondents raised the issue of change of idea Based on the findings in this study, participants' years of stay in South Africa varied from one year to nine years. The younger generation (1-5years) exhibit more acculturated behavior than the older generation (5-10 years). The researcher found that all the participants attested to a change of idea towards condom use.

## **Change of idea**

All the participants shared their insights of the idea of condom as compared to their home countries. Most of the respondents declared that the notion of condom in South Africa is community friendly compared to their countries of origin.

Condom use in my home country it is like a taboo in my country which is Cameroon they consider it since it is related to sexual act as been very immoral what will the people say so it has to be treated with privacy so even the means of getting the condoms it is not easy to go into a shop and request for a condom because you will be shy not knowing how will the community look at you or the people who sell to you how will they look at you (*35 years old married male*).

From my own analysis the two countries have different view of condom why because the way the two countries look at sex from different approach in my country sex is not something you hear of everyday while in South Africa the use of condom is very normal to people in Cameroon this is very strange (*21years single male*).

Conversely, they also ventured that the idea of condom and its free distribution, cannot be separated.



Yoho when I came here I discovered that they distribute condoms every houses I was so happy. If you compare Cameroon and South Africa the idea here is so broad *(23 years old single male)*.

Notwithstanding some of the above participants indicated that though the information about condom is available in South Africa, the indigents have yet to utilize it.

I will say people don't really care about condom usage here from what I have heard, learnt from other people and seen here in South Africa people neglect condom usage a lot even though they have the opportunities to use them and having them for free *(31 years old married female)*.

The idea of condom in my country Congo and here I can say in South Africa is very dangerous because here you use more condom *(26years single male)*.

Culture was not left out as the 35years old respondent declares that the lifestyle of the both South Africans and acculturated migrants will definitely determine their condom use behaviour.

We have found different things here in South Africa where you find where you will be living with a girl without knowing her parents, she doesn't know your parents or where she came from because this will determine how you use condom *(35 years old married male)*.

While very few respondents affirmed that condom use in South Africa is associated to many girlfriends and the high rate of HIV.

People most of them using condoms go out with more ladies that taking advantage so they can be safe I think using condom is a way to protect yourself from pregnancies, HIV and other diseases. Not having the idea of carrying more girls because of condom (34 years old married male).

Though the participants are in the receiving country, the little voices echoing the media's positive teachings of HIV have enhanced their attitude towards condom use.

The idea of condom just before I came I had in my brain it is all over the TV that South Africa is the country with the highest HIV so I put that at the back of mine that I will not get into sex with a lady without condom (21 years old single male).

However, one respondent said the idea of condom is universal with the sole purpose of protection.

Even here or in Congo condom doesn't change it is there to protect people so it is the same to protect people from sicknesses (33 years married male).

Notwithstanding, few of the married female participants from Congo shared their deep dissatisfaction with the idea of condom in relation to children.

I don't like the way they are teaching the small child is like they are pushing them to have sex before age but us they just show us the bible that having sex before marriage is not nice. Like a small child in South Africa I always see that by the school they are talking

small children about condom it not nice they are not supposed to do that it not nice. *(26 years old married female)*.

#### *Free access of condom*

The majority of the respondents expressed pleasure at the fact that condoms in South Africa were readily available unlike in their countries of origin:

It is easy to get condom here than in Cameroon because in Cameroon you buy, it not for free *(22 years old single male)*.

Here it is easy because everywhere you pass train station, in the hospitals, in school you will find a box. Everywhere you pass you can find it, but in Congo you have to buy *(25 years old single male)*.

The respondents also indicated that despite having to buy condoms in their countries compared to South Africa where it is freely distributed, other problems were highlighted. Few respondents shared the psychological barriers they encountered when purchasing a condom.

It is easy to access condom here than back home. Back home if you go to buy condom from a shop and it is an elderly person selling them the way he will look at you even if he will sell it because he needs to do business but here is normal. In Cameroon condoms are not distributed freely we do buy them *(21 years old single male)*.

People don't feel free going to the shores to purchase condoms. They feel ashamed. Condoms are not shared to the communities so that we can have access to the condoms like here in South Africa there in my country you buy it *(23 years old single male)*.

From all the above responses, it is of importance to note that free distribution of condom is what every government should implement. However, this should be done alongside education to enhance the proper and safe use of condom. Nonetheless, participants from Cameroon and Congo whose governments do not offer free condoms may suggest why the youth indulge in unprotected sex and at times are judged when they try to purchase the condoms. The fact that people do not feel comfortable to buy condoms in the public could be a factor that makes them to end up indulging without protection.

### **Risky sexual behaviour**

Empirical studies have indicated that youth fall under the category of people who indulge in risky sexual behaviour. Despite the above majority of the single participants voiced their involvement in risky behaviour as the change they experienced in South Africa, only few reported less risky behaviour based on their ability to adhere to their religious beliefs.

Yah my sexual behaviour have changed made to gone into too much relationship with the opposite sex sometime I sit and think I look at myself and feel ashamed of what I have done. I am still looking for the lady it because I don't have that lady *(22 years old single male)*.

Yes it has changed my behaviour because in South Africa the idea of sex when it comes to the community it is something people have embraced they are not scared, it doesn't sound strange. People they are used to it so I have tilted to that way of living as well (23 years old single male).

The Youth Risk Behaviour Survey (CDC, 2013) found that nationwide in the United States, 34.0% of students had had sexual intercourse with at least one person in the last three months before the survey. In a previous study conducted with South African youth, The Youth Risk Behaviour Survey (2008) found that past three months 52.3% almost one in two participants were sexually active (vaginal or anal).

*No cost*

Interestingly, participants backed their risky sexual behaviour with the high rate of promiscuity practiced by some South African youth.

It has really changed because back home there is a cost but here you can have as many as you want (24 years old single male).

Here my sexual behaviour has changed because here we have access to many girls they are cheap and condom also is for free (20 years old single male).

According to the research findings, the researcher found that, despite the factors raised above 1 of the participants' portrayed favourable change of attitude while 1 respondent stayed unaffected.

Yes ha-ha ha-ha it challenged I did change because I know South Africa is dangerous in HIV . Yes my behaviour changed for the good because it makes me know my use of using my condom (21 years old single male).

Nothing has changed I live here the way I used to live back home (25 years old single female).

Nonetheless, according to Upchurch, Aneshensel, Mudgal, and Sucoff McNeely (2001), when acculturation is taken into account, there is little difference between more acculturated males and females regarding their sexual behavior. Suggesting that, more acculturated youth, irrespective of gender, have more tolerant or nontraditional values about sex than their less acculturated peers. The reach found that although most single migrants' behaviors have changed in South Africa, few maintained remained unchanged.

#### **4.8. Barriers & challenges towards preventive health care provision**

The respondents highlighted what they considered to be barriers and challenges towards health provision and these included; lack of proper documentation, perceived negative attitudes of the health staff, long working hours and the shortage of staff. Each of these issues will be discussed in detail below.

##### **Lack of documentation**

The research data also found that, some respondents indicated that the lack of proper documentation also contributed in their inability to receive better treatment from the health workers:

Sometimes the thing is that we are not been treated fairly they ask for proof of income your physical address, you documents a lot of time people prefer to pay in the private rather than going to the public because of the kind of treatment they get there *(24 years old single male)*.

I think in the clinics where they offer such services and you cannot access the clinics without legal documents because in the clinics you cannot receive preventive health care if you do not have documents *(31years old married female)*.

Participants related some of the barriers they encountered in the clinics. The next respondent declares that the inhumane treatment bestowed on migrants is a portrayal of xenophobia.

I wish they could treat foreigners as humans because they don't treat them as humans. Sometimes they demand for documents you don't have like even ID. There is a lot of discrimination and xenophobia. They should treat them as they treat the nationals *(25years old single female)*.

The research data also seem to indicate the importance of documentation without the proper or no documentation as expressed by the respondents' one was likely not to receive better treatment at the health centres. It would also seem that the health workers used the issue of documentation to tell who is a South African and who is not thus determine the type of the service one is given. However the denial of one to basic services such as health is in violation to the Constitution of South Africa (1996) that advocates for the rights of everyone to basic health further affirms the

responsibility of the state to take realistic legislative and other measures towards achieving a progressive realization of the above right. From the above experiences shared by respondents, it is obvious that migrants encounter some extent of difficulties in their attempt to access health care services. The state has to act by implementing policies in the health sector which will accommodate those who are vulnerable as the migrants.

#### *Free services*

All migrants who took part in this research affirmed the lack of free health services in their home countries. As the purchase of condom, the findings indicted that the governments of participants practice a payment before service system in the health facilities. Most participants were happy with the free services rendered in terms of cost, while very few respondents preferred to seek private services because of time constrain.

Yes I was happy because I did not spend any money because back home you pay money and you will not be attended as you want (31 years old married female).

I was very happy with the services because it was for free back home you have to pay for it (23 years old male).

The research findings further illustrated the fact that free services were a relief to the respondents as they would have money to save and send home, unlike the payment required in their country. The fact that the services were for free may be an attractive factor to the migrants to seek the health services despite the issue of staff shortage.



## **Shortage of staff**

Another issue that came out of the findings was the fact that South Africa faced a tremendous skill shortage in the health department as demonstrated by the comments of the respondents below: as employees ventured overseas for better salary and flexible working hours. By Also, the pull factor experienced by major cities such as Cape Town where internal migrants flood in to seek better services and treatment. These and other reasons have affected the staff capacity in the clinics and hospitals. They claimed that:

At times when you go to the clinics the cues are usually long before you can be attended to. The clinic always complained of lack of staff or shortage of staff (*31years old married male*).

Humm actually there is no challenge but the point is that there you don't find more doctors in place that is what the hospital are facing it is not what us we are facing it is what the hospital are facing many people who are coming there in other to access all of them it very difficult to finish with all those patients who are coming there (*25 single old male years*).

The comments of the respondents indicates that as a result of the manpower at most of the health facilities, those seeking health services are made to wait for longer hours before they are served. On the other hand the respondents also attributed the long hours of waiting before one could be served to the increase in the number of people seeking services thus increasing the workload to

the health personnel. With the services free at most of these health centres, it may also explain why more and more people could be opting to seek health services at these places as they know that they will not pay anything. It therefore also follows that in situation where services are offered for free health workers are more likely to be overwhelmed by the situation thereby ending up rendering substandard service.

### *Negative attitude and negligence*

Negative attitude and negligence of some health professionals towards migrants has become acceptable practice in some health faculties in South Africa. Below are respondents affirmation.

I was involved in an accident in my car the ambulance services was quick but when I got there with bleeding and swollen face I was left there from 4 am to 11 am in the morning if had internal bleeding I would have died. May be it was because my colour because I was bleeding badly even from my nose (*24 years single old male*).

They don't give us much attention. Yes they always complain about is short staff. Like the other time when I go with my baby my baby was very sick a baby for two months was sick it was cold the nurse was busy with the phone he was supposed to call me but he didn't call me and the girl friend come and jump the queue go straight to him and that time I got anger and knock there and say

the first person come the first person must be serve I sit there for  
more than four hours (*26 years old married female*).

It would appear from the research findings that migrants seeking services in urban clinics are in most instances denied services based either on lack of documents or some preconceived perception by health workers. Landau & Singh (2008) argued that one of the effects of migration is the problematic access to healthcare services. To Endeavour that health facilities, goods and services are available, accessible, acceptable, of proper value and appropriate to all segments of the population, including migrants (IOM, 2013), there may be a need for a mind-set change amongst health professionals.

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## **CHAPTER FIVE: CONCLUSIONS**

The purpose of this study was to explore the factors that influenced the use of condom as preventive health behaviour among migrants' youth in Cape Town, South Africa. The researcher studied attitudes, subjective norms and behavioural intentions of these youth as migrants. The Theory of Acculturation, Planned Behaviour and Reasoned Action was used to design this study and data collection instruments. The chosen methodology of using in-depth interviews proved to be effective in this regard. The purposive sampling strategy was used to locate 20 migrants aged 18 to 35 years cohort who were interviewed. A snow balling method of collecting data was used where a semi structured questionnaire was implemented. The data was then collected and analysed. This chapter presents the conclusions drawn from each objective of the study and proposed recommendations were applicable. Further recommendations for future research will be accorded to address present gaps.

In terms of migrants' attitudes towards condom use, they demonstrated a positive outcome to their regular use of condom. These positive attitudes could be attributed to the level of information they have acquired regarding HIV and preventive health and their ability to act upon this knowledge. Notwithstanding, majority are involved in risky sexual behaviour which is a cause for concern. One night stands, multiple partners and excessive drinking are activities which these youth indulge in. These factors can blur their ability to negotiate safer sex. The idea that condom was not 'flesh to flesh' was prominent amongst the single male participants who view it as a pleasure barrier. The research found that, although majority of the respondents did not find condom pleasurable or stimulating, they were all bent on using it for safety reasons.

Nonetheless condom was only used with girlfriends and not partners. They perceived that condom usage was not required for people in steady and established relationships. However their continuous indication of how unreliable condom was created the opportunity for more education.

Subjective norms impact on condom use behaviour and intentions of migrant youth in this study. Everyone in life has that referent other whose opinion they value. This opinion may to certain extend influence positively or otherwise the behavioural intentions of an individual. In this study the researcher found that, the most important people in the lives of the participants were; parents, siblings, pastors, partners and friends. However, these categories of people played different roles in the lives of the respondents. The role of parental norms in behavioural intentions was central for all respondents irrespective of marital status and years of stay in South Africa. Having strong parental norms was shown to increase positively their intentions towards condom use and testing for HIV. The role of religious leaders represented by the pastor indicated a theoretical belief of the principle of one man one woman. This however was not real in majority of the single male participants, who could not incorporate the ideology into action. Though the findings showed that the married participants were faithful to their partners, condom use and other preventative health measures were not discussed frequently on the basis of trust. The issue of stigma was raised in relation to friends' norm as well as trust.

Interestingly the study found that, Perceived Behavioural Control influenced the condoms use behaviour among migrant youth. All the single migrants who participated in this research portrayed a progressive perceived behavioural control over their ability to say no to sex without condom and act upon it. However, those in the married category struggled in this area. The researcher found that, though women were more positive than men in relation to two aspects;

sexual responsiveness and relational issues, men were comfortable around issues of embarrassment and the purchase of condom. Nonetheless these positive attitudes perceived by the female respondents could not be translated onto practice because firstly, the condom commonly used is the male condom which in most cases can be bought and used by men.

It could be concluded that acculturation does influence condom use behaviour and intentions of migrant youth. The theory of Acculturation was one of the theories used by the researcher to analyse the data collected. The study found that, acculturation influenced migrants sexual behaviour negatively. Single male participants who reportedly had one partner in their respective home countries now have multiple girlfriends. Nonetheless, the researcher found that the easy access to condom and availability of young girls in South Africa has to a certain extent sponsored this growing habit of risky sexual behaviour. Furthermore, idleness was another factor which the study found to influence the migrants acculturated appetite for multiple girlfriends.

It is against these findings that the researcher hoped to conclude that in the course of time, the new generation of acculturated single migrants have the potential to shift to being faithful to one partner after marriage. Though this might not apply to all it should not be overlooked. According to findings of the research, most migrants are likely to marry at a certain age. Culturally, marriage demands these migrants to work and feed the family that is less idleness and the drive towards one man one woman principle.

According to the findings, migrants experience certain challenges and barriers towards accessing preventive health care services. Most migrants find themselves in compromised vulnerable situations where they are incapable of making relevant choices pertaining to health. Preventive health in such predisposed cases becomes an essential other ingredient for their safe

living. However, when this is flawed with challenges and barriers in the health system and service providers, migrants become susceptible to more abuse. In this study, the researcher found that, migrants perceived to have been treated poorly by the hospital staff in many occasions. In some cases the study found that they were denied care to health because they lacked proper documentation. The study further established that the health professionals such as; receptionists, clerks, nurses and front line personnel's may need more information on the rights of a patients, as endorsed by South African constitution and the basic human right practices. However, the free services offered to migrants is a plus to the South African health department as all migrants attested to the payment before service model practiced in their home countries.

The purposive and snow balling methods employed in this study utilized convenient limited samples of 20 migrants in Cape Town. As a result these findings cannot be generalized to the entire migrants' population in South Africa. For these reasons, it is necessary for further research in a larger scale and also less convenient samples such as migrants in prison. It will be further useful for researchers to conduct a quantitative study on this topic to strengthen the evidence. This could be conducted to work as the predictors of condom use intentions.

Furthermore, the researcher found in line with (Conner & Armitage, 1998; Landridge et al., 2007) that, the hypothetical variables on health behavioural intention of migrants are limited and may to a certain extent suggest inadequacy of the theories employed. Conversely it would be wonderful for South African researchers to take interest in exploring the inclusion of other variables applicable in the African context to those associated with the theory of planned behaviour and reasoned action.

It could be concluded that the population of South Africa is not ignorant of the facts about HIV/AIDS since it became topical in the 1980s. The media has done a tremendous job in their attempt to educate the masses through adverts, movies and other entertainment tools. Notwithstanding, various research piloted by social science has covered a variety of topics, without specifically emphasising on how preventive behaviour can be formed in a situation where the voices of other role players can affect ones behaviour



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## Appendix A

### Consent Forms to Participate In the Condom Use Interview

Page 1 of 2

Project Title	An elicitation study of the condom use behaviour and intentions of migrants youth in South Africa
Purpose	This research project is being conducted by Aunt Tantoh and supervised by Dr. Johannes John-Langba of the University of Cape Town. We are inviting you to participate in this study because you are a migrant between the ages of 18-34, and live in Cape Town. As part of the requirements for the degree of MScs the purpose of the research is to determine if attitude and subjective norms can influence behavioural intentions towards condom use.
Methods to be used	One-on one interview. Our discussions will be audio taped to help me accurately capture your insight in your own words. For the purpose of this study the tapes will heard only by me. Likewise if at any time you feel uncomfortable with the tape recorder, you may asked that it be turned off.
Confidentiality	The investigators promise to keep all the information confidential as required by law. To help protect your privacy and confidentiality, we will not ask for your full name, physical address or any other information that may identify you. The researcher will only take notes of your suggestion and comments and will use this information to make changes to the final draft of the survey. Because her notes will not have your name on them the researcher will be unable to link the information to you. All information written down by the researcher will be locked in a locked cupboard in the supervisor's office, in the university of Cape Town. The information will be destroyed 12 months after the survey and only the researcher will have access to the survey. If during the study you disclose to us that you are victim of neglect or abuse by either your parents or spouse, or that your child is a victim of neglect or abuse, I need to inform the child welfare services.
Risks	There are no known physical risks associated with participating in this research. It is possible that you feel uncomfortable answering some sensitive questions about sex.

Project Title	An elicitation study of the condom use behaviour and intentions of migrants youth in South Africa	
Benefits	This research is not designed to help you personally but the results may help the Researchers learn more about what the sexual health services youths need. We hope to use this information to improve youth programs in South Africa.	
Freedom to withdraw	Your participation in this research is completely voluntary. You may choose not to take part at all. You may stop participating any time. You will always be able to use identity Inc. Services no matter if you decide to participate or not participate.	
Medical treatment	The university of Cape Town does not Provide any medical hospitalization or other insurance for participating in this research study nor will the University of Cape Town provide any medical treatment or compensation for any injury sustained as a result of participating in this research study, except as required by law.	
Ask questions	You are encouraged to ask questions or raise any concerns at any time regarding the nature of the study or the methods I am using. Please contact me any time at; <a href="mailto:auntietantoh@yahoo.com">auntietantoh@yahoo.com</a> or call at 27 081 008 2102.	
Age of Subject & Consent	your signature indicates that: you are at least 18 years of age the research has been explained to you; your questions have been fully answered and; you freely and voluntarily choose to participate in this research project.	
Signature and Date	NAME OF SUBJECT	
	SIGNATURE OF SUBJECT	
	DATE	
Thumb Print		

## **Appendix B**

### Research Interview Schedule

#### In-depth One on One Interview Schedule

(Migrant youth in Cape Town)

#### **Personal Information**

Gender (Male /Female): \_\_\_\_\_ Country of Origin: \_\_\_\_\_

Date of Birth/Age: \_\_\_\_\_ Place of Residence \_\_\_\_\_

Type of Permit: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Education Completed: \_\_\_\_\_ Employment: \_\_\_\_\_

Focus Notes: \_\_\_\_\_

#### INTRODUCTION

- a) Thank you for agreeing to have this interview.
- b) I am Aunt Tantoh a research student from the University of Cape Town. The aim of this study is to explore the factors that influence behavioural intentions and attitudes of young migrants towards condom use.

- c) Please feel free to talk openly. If you feel uncomfortable talking about something, or would rather not answer a question, please tell me. You do not have to answer questions if you do not want to.
- d) Time: The interview will take up to an hour and half... If you are tired, or need to stop and do something else, please tell me and we can take a break.
- e) Confidentiality: Everything said in this interview will be treated as confidential as possible by the researcher. When I report on the findings, I will make sure that everybody remains anonymous.
- f) Recording: Do you mind if I record this interview? It's only for research purposes. That way I don't have to write down lots of notes while we talk. I will be the only one to listen to the recording. Please speak clearly so that I can hear what was said on the tape.
- g) **Test recording:** Before we start, I would like to make sure that the tape recorder is working properly. (Interviewer: start recording: my name is Aunt Tantoh and today is the \_\_\_\_\_ of July, 2014. How do you feel about this year's winter? How old are you and what kind of job are you in. the researcher will ask the participant this question while they are sitting in their natural position where they will sit for the interview. The researcher will stop the recording, play back to make sure it is working and that both voices can be heard.)

### **Background Knowledge of condom use**

1. What do you know about condom?
  - Where did you get the information from?
2. Do you remember using a condom the last time you had sex?



- If yes please explain
- If no give reasons why

3. Who brought the condom?

- Was it you or your partner?
- Give reasons why you /your partner brought the condom

### **Intentions**

1. What are your intentions concerning condom use?

- Do you intend to use a condom every time you have sex?

2. Are you planning to go for an HIV test?

- Explain why you intend to go for an HIV test.
- How many sex partner/s do you expect to have?

### **Attitude**

1. What do you think is your opinion concerning seeking an HIV test?

- Would you use a condom regularly during sexual intercourse? Explain.
- What would you say is your opinion regarding the effectiveness of condom as a birth control method?
- Would you say that condoms are unreliable? Explain

2. Do you find pleasure with condom during sexual intercourse?

- Does the use of condom help stimulate sex? Explain
- Would you say that condom use is uncomfortable or fun during sexual intercourse?

3. How will you identify a man or woman who suggests the use of condom?

- If a man suggests condom use during intercourse do you think sex will take place?
- Do you think that women who suggest condom use do not trust their partners?

4. How easy or difficult is it for a man or woman to negotiate condom use?

- What do you say when you negotiate condom use with your partner?

5. How do you feel about the purchase of condom?

- Do you feel embarrassed or comfortable when buying a condom? Explain

### **Behavioral Beliefs**

1. How much or less would you say you love or value your partner?

- What would you say about having only one sex partner?

2. Would you say that going for an HIV test shows that you care about your health and your partner's health? Explain

3. How will your use of a condom during sexual intercourse affect unwanted pregnancy and sexually transmitted infections? Explain.

4. How does your regular use of a condom guaranty your safety?

### **Subjective Norm**

1. Who are the people you think are most important to you in terms of your sexual behavior or intentions.

- What will the people you love and care for (siblings, partner, religious leader and friends) think about you testing for an HIV and using a condom?

2. What are the expectations of your (religious leader, friends, siblings and partner) concerning the number of partners you should have.

- Do you always comply with what your (pastor, friends, partner and siblings) are saying?

### **Normative Beliefs**

1. What are the opinions of your partner and parents concerning staying faithful to one partner?

2. How would your friends and family feel about you getting to know your HIV status?

3. How would your friends feel if you did not use condoms?

### **Perceived Behavioral Control**

1. Would you say that you can refuse sex without a condom if you want to? Explain
2. Would you say that it is easy for you to stay faithful to your only partner? Explain
3. Would you say that wanting to test for an HIV is it completely up to you? Explain

### **Acculturation**

1. How long have you been in South Africa?
  - How different is the idea of condom use here in South Africa from your home country?
  - How has living in South Africa influenced your sexual behaviour
2. Would you say that it is easy or difficult to access condom back home than here in South Africa?
3. Did you or did you not use condom back home during sexual intercourse? Explain.
  - How will your culture influence condom use?

### **Challenges and barriers**

1. Do you know of any place where you can get help regarding preventive health?

- Who told you about this place? Explain.

2. What are the challenges or barriers you face as a migrant towards preventive health care provision?

3. Since your arrival in South Africa, have been to any clinic?

- Where you happy or not happy with the services you received? Explain
- What would you like to see change in these facilities?

THANK YOU VERY MUCH FOR PARTICIPATING IN THIS STUDY.

IS THERE ANYTHING YOU WOULD LIKE TO ADD OR ANY QUESTION YOU WOULD LIKE TO ASK?